EMERGING ISSUES OF IDENTITY AND LANGUAGE SOCIALIZATON IN THE PROCESS OF REACCREDITATION FOR REGISTERED NURSES EDUCATED ABROAD

by

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Abstract

This study examines how foreign educated nurses experience the acquisition of the language and culture of nursing in Canada through the process of reaccreditation. The study explores five nurses' perceptions in the following areas: a) the nature of nursing in which they were socialized in their own country and in Canada; b) how they became socialized into the culture of Canadian nursing through the reaccreditation process and programs designed to assist them; c) how they will continue to be socialized after reaccreditation as working professionals in Canada. A life history approach was used to explore the nurses' perspective on nursing across language and culture within a chronological or developmental framework. The voices presented in the stories belong to five nurses who were successful in obtaining reaccreditation after completing two programs designed to assist them in fulfilling the licensure requirements and in preparing for work in the Canadian health system. Five life stories were collected through interviews which were then edited and analyzed.

The themes in the stories appear to indicate that in these nurses' view, first of all, their identity as nurses underwent a complex interplay involving elements, some of which remained constant (the notion of caring) and others which are manifested differently in different cultures and must be learned (how to approach patients). Secondly, the nurses in the study indicated that the programs in which they participated, in particular a refresher program, were invaluable in preparing them to be competent, confident nurses in Canada. Two components were identified by the nurses as being particularly valuable, one was the Communications course, where they learned the language and communication of care that is culturally appropriate for Canada; the other one was the clinical practice, where they saw first-hand how nursing is practiced in this culture, and had the opportunity to integrate their

previous knowledge and experience with the newly acquired theory. The ESL components of these programs did not meet the nurses' expectations. According to the nurses, the ESL classes were designed primarily to help them obtain the required scores on the TOEFL and TSE, two examinations which they saw as not being indicative of language proficiencies required for nursing. The five women felt that most activities in the ESL class were decontextualized, neither supporting them with the academic language needs of the nursing courses, nor preparing them for the language needs of the workplace. Finally, all the nurses in this study currently work in the Canadian health care system. They describe how they continue to be socialized into the culture of nursing and reflect on changes in their sense of being nurses in Canada. At the end of the study, implications were drawn for further research and practice.

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ACKNOWLEDGEMENTS

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To my parents and grandparents, thank you for giving me first-hand knowledge of border-crossings; of what it is like to move and to live in the border-crossings of language, culture and identity. To my three sisters, Irma, Cristina and Monica, thank you for giving of yourselves in different ways. Thanks to my extended family of relatives, friends and colleagues for their support, encouragement and for listening to my ideas as they emerged. Thank you Grant for reading, asking, discussing, and lovingly witnessing. And most of all, thank you my dear Cecilia, for who you are and for teaching me the most important things in life.

Chapter One

Introduction

1.1 Background Stories

Life Histories of Foreign Trained Nurses: I am connected to this study through three generations of my own immigrant history and through my recent work history in ESL employment training programs. They are like strands or yarns that reach out and want to connect with the yarns of other histories, the histories of the nurses in this study.

1.2 The Immigrant Grandmothers' Stories

I wish I knew more about the lives of my two immigrant grandmothers. They left their native Germany, in economic tatters after World War I on their immigrant quest, a better life for the next generation. The search took them to Argentina, where I was born and grew up hearing them tell stories about the idealized homeland and the hardships of the new country. I wish I could have been older, asked more questions, listened more carefully. I need those stories to make more sense of where I come from; of who I am now as an immigrant in Canada, re-working once again old stories, now my own old stories.

I have been able to reconstruct some of this history through a book a friend brought me back a couple of years ago from his visit to Argentina. *Allá en la Patagonia (There in Patagonia)* (Brunswig de Bamberg, 1995), is an account of immigrant life in Argentina in the mid-twenties told by a German woman through her letters to her mother. It was a precious gift, a window into my past history. I was able to get a look from the inside into my grandparents' experiences, recognize many of the stories, attitudes, understandings that I had glimpsed as a child.

Doing these life histories of immigrant women I hope will contribute to establish an account that might otherwise be lost. An account that would be of significance, first to the women involved, and to others interested in an insider's perspective on immigrants, women and health professionals.

1.3 My Mother's Story

My mother, like the women in the study, was a nurse trained abroad. Unlike the women in the study, she did not attempt to re-qualify to work as a nurse when she came to Canada more than thirty years ago. Why not? I remember she briefly considered it but language, the fifteen years she had been away from the profession, and four young daughters were the reasons she gave for opting instead to stay home and run a 10-acre apple orchard (an occupation for which she had no experience) while her husband was away for whole months at a time working on construction projects all over the province.

I wonder if she would have made a different choice had there been programs in place like the ones the nurses in this study were able to access. If she could have been with a group of women in similar circumstances to hers, with family responsibilities, not being familiar with nursing practices in Canada, needing to develop language proficiencies, would she have made a different choice?

Like the nurses in this study her identity as a nurse was important to her. I remember, from time to time, hearing my mother when she got tired of the household drudgery, wonder out loud if she had made the right choice in getting married and giving up her professional career as a nurse. As for any child, I was surprised that my mother would see herself as anything else but a mother. I also remember, years later, when I needed some last minute

listening practice material for one of my Spanish language classes at the university, begging my mother to record for me a few minutes about her experience at her first job. I was amazed at the transformation I witnessed as she told her story of being a nurse. The woman who often said she was shy and not very articulate, took on a persona I had not seen before. She spoke very self-assured, with a strong voice and straight, composed body about what it had been like to work as a nurse in a cancer clinic in the forties in Buenos Aires. I saw then how telling a life history can transform a person. I also saw how important nursing had been for my mother.

My mother's story connected me to the stories of the five immigrant women in this study, all of them proud of their profession.

1.4 My Stories

My history also connects me to the tapestry in this study. When I came to Canada as a teenager, I was thrown into the bewilderment of trying to make sense and survive in a new culture. An important part of this new culture was school. In the late 60's in a small town in the Okanagan, my sisters and I were placed in an age-appropriate class with no special language instruction. That was my first-hand experience with language socialization, language immersion, learning language through content and academic ESL. I also learned that to be a confident participant in the high school culture, the language that I needed to succeed academically, was different from the language I needed to interact with teachers and, what was even more puzzling, with my peers. Somehow, the language for Social Studies was easier to grasp than the language I needed to make friends; there was more to it than knowing grammar and vocabulary.

In those two years of high school I also learned that lack of language can close doors to future education and career options. After three months of school I, along with all my classmates, had to decide whether to finish school in the vocational stream or in the academic stream. I remember sitting in the counselor's office, being steered into the vocational stream, as a program that would be less demanding, more feasible for me considering the difficulties I was experiencing with English. I remember trying to understand what was being explained to me, trying to sort out the school system here, asking questions about the implications of this choice and finally attempting to put my view across as clearly and strongly as I could that I wanted to go on to university and that I wanted whichever program would get me there.

Other strands that weave into this study have to do with my connections with the lives of newcomers to Canada who left behind years of education and work experience as professionals in their countries to face the frustration and despair of not being able to work in their field. There were the many Chilean political refugees, family, friends: the accountant working as janitor, the unemployed architect. There were the participants in ESL re-employment programs I coordinated over a span of five years: the nuclear and environmental engineers from China, the film director from the Ukraine, the naval engineer from Poland, the ceramics engineer from Romania. The people were struggling with the realization that their education and experience had no value here, that there was no mechanism, or path to have their credentials recognized in their new country.

This study looks at a group of immigrant professionals with a different story. For them there was a way to get re-accredited and to continue working in their professional fields.

1.5 The Story of Nurses Accredited Abroad and their Program

Three years ago I worked with a now discontinued federally funded program that provided a combination of English language training and orientation to the profession of nursing in Canada. The program I coordinated was for registered nurses who had come to Canada as immigrants or refugees and were seeking reaccreditation from the local nursing professional association in order to work in their new country.

1.5.1 Nursing Reaccreditation Requirements

Nurses educated abroad (NEAs) in a language other than English have to fulfill several requirements set out by the Registered Nurses Association (RNA) of their province. NEAs must a) show proof of equivalency of education and work experience abroad; b) establish language proficiency; and c) pass the Canadian Nursing Examinations. In addition, nurses who have not worked as such for more than five years, must complete a refresher program. Before being considered for reaccreditation, RNs must have the educational institutions where they obtained their degree send the association original transcripts detailing courses taken and length of each course including clinical practice to determine if their training is comparable to the training offered here. Documentation is also required from institutions where nurses worked, outlining length of work experience and areas of work. The documentation must be sent directly from the issuing institution and must be translated into English. For some RNs this process is straightforward and does not take a long time, for others it can be fraught with delays. One of the purposes of the nine-month program I coordinated was to support nurses who had not completed the evaluation of documentation, by sorting out options when they encountered a complication in obtaining the documentation.

Some of the difficulties nurses in the program encountered included dealing with slow unresponsive bureaucracies requiring bribes or ongoing prodding from friends or relatives who sometimes had to travel great distances to intercede on the behalf of the RN in Canada. Miscommunications regarding where the documents were to be sent also meant delays. Conditions of war and civil strife in the country of origin meant that communications with the outside world were difficult or impossible. In one case the university hospital from which the RN had obtained her education had been converted into a refugee camp and records were not available. In the case of a nurse from Vietnam, the professional association here did not have sufficient information on the nursing programs in Vietnam to determine equivalency.

As well as providing documentation on education and work experience, applicants must show proficiency in English, demonstrated by obtaining a score of at least 550 in the Test of English as a Foreign Language (TOEFL), and 50 for the Test of Spoken English (TSE). After these requirements have been fulfilled, NEAs are eligible to sit for the Canadian Nurses Association Test (CNAT). This is the same examination graduates from Canadian nursing programs must pass in order to be registered as nurses. To prepare for the examination, NEAs either study on their own, hire a tutor to prepare them or join a refresher program offered by a local community college or by distance education. The process of reaccreditation could be a lengthy process for a candidate depending on factors such as how easy it is to obtain the required documentation or how close they scored to the requisite 550 TOEFL. This process, however, is atypical of the support available to most foreign trained professionals.

1.5.2 The Case of Other Professionals

Professionals are a category of applicants for immigration favoured by Canada. Level of education and knowledge of one of the official languages have been criteria valued in the point system which determines eligibility in granting immigration visas. Professionals, by virtue of their education and privileged financial position in society, are a group most likely to have obtained language training in English in their country of origin. Professionals continue to be favoured as applicants with recent proposals by the Federal government requiring proficiency in one of the two official languages. The rationale being offered by the government is that immigrants who can speak English or French at the time of entry would be less of a financial burden on the Canadian tax-payer since they would not have to take language training classes such as LINC (Language Instruction for Newcomers to Canada) currently financed by the government. Furthermore, they would be ready to find employment more quickly than someone without knowledge of the language. These assumptions are congruent with the labour market training programs for non-native speakers (NNSs) I saw in my five years working in the field. The majority of the programs are designed for non-professionals in the service sector, such as hospitality workers, long term care aides, painters. While most programs for non-professionals offer language training combined with training in a particular occupational field, programs for professional NNSs follow a short-term job club model emphasizing job search skills in non-professional areas related to the student's profession. For example, an electronics engineer may be encouraged to seek employment as an electronics technician, with the assumption that this would be a first step for the immigrant that would eventually lead to a position as professional engineer having established some references, become familiarized with the field, and been able to improve

the knowledge of English for that professional context. However, although NNS professionals who immigrate to Canada may have a functional knowledge of English, the assumption that they will easily adapt to their new country or that they do not need the support of language training in order to make a successful transition into the labour market, needs further consideration. Recognition of professional credentials, reaccreditation, entrance into professional associations, employment within a professional field, knowledge of professional practices in Canada, as well as the subtleties of communicating in a new language within a new professional context are some of the issues facing NNS professionals. In terms of their need for support programs, although they may have a language proficiency higher than what is considered for LINC programs, professionals may require more advanced and specialized language training tailored to their needs.

This study presents the voices of five professionals who were successful in re-entering their fields. To assist in the process of reaccreditation, unlike other professional groups, RNs have programs designed to assist them. These are combined skills programs in English as a second language (ESL) and nursing which help prepare nurses to pass the language and nursing examinations set out by the professional association. There is a lack of research around the process of language socialization of immigrant professionals, in other words, the process by which professionals gain knowledge of the language in the context of their specialized field. In particular, there have been no qualitative studies made on the process of language socialization of RNs trained abroad who seek reaccreditation in Canada. Thus questions such as the following have not been explored: what is it like to prepare for reaccreditation in a professional field in a foreign language, what do foreign trained nurses

need to learn to be re-accredited and to be competent RNs in the Canadian context? What specific areas of difficulty are faced by NNSs? How do NNSs face these challenges?

1.6 Research Questions

The preceding sections outline the general background and focus for this study. The overarching question is: How do foreign educated nurses experience the process of seeking to work again in their profession, once they immigrate to Canada? The process is explored through the nurses own accounts by using life histories. More specific research questions are:

1. How do foreign educated nurses perceive the nature of nursing in which they were socialized in their own country and in Canada? That is, what are the social, cultural, linguistic, and professional norms and values of the occupation as perceived by nurses seeking re-accreditation?

2. How do foreign educated nurses become socialized into the culture of Canadian nursing through the reaccreditation process and programs designed to assist them?

3. What are foreign educated nurses' perceptions of language socialization after reaccreditation? In other words, how do they predict they will continue to be socialized into the profession of nursing in Canada?

Chapter two will review some of the literature that is related to these questions. Chapter three will look at the rationale for selecting life stories as a method for the study and

at how the stories were collected, shaped and analyzed. The nurses' life stories are presented in chapter four. Chapter five examines themes emerging from the stories. In the final chapter, chapter six, I summarize the findings, look towards future directions of study and implementation and, conclude with some reflections on my participation in this study.

1.7 Definitions

In this section, I will include a short list of terms and definitions that may serve as quick reference to the reader.

Care, Types of

Acute care: consists of emergency and critical care in hospitals.

Day care: a community service providing care for adults once or several times a week.

Long-term care: provides "services and care for those who have health-related problems and cannot live independently without help." (Illerbrun, 1991, p. 82) The following are part of the long-term care system:

Home Care Services: "for the client who is able to remain at home with some assistance." (p.82)

OR for clients who are not able to stay at home:

Personal Care: "for clients able to look after themselves with minimal help and supervision. No registered nurse is required." (p. 82)

Intermediate Care: "for clients who require general support and some professional care but are still able to do much for themselves. Staff must include a registered nurse at least part-time." (p.82)

Extended Care: "for clients who need to have professional health services available at all times. Staff must include a registered nurse for 24 hours of a day." (p. 82)

CNATS or CNAT examination: licensure examinations from the Canadian Nurses Association Testing Service (CNATS). Nurses are required to pass the exams in order to be licensed to practice as nurses. Foreign educated nurses sit for the same exam as do graduates from Canadian universities.

Nurses Educated Abroad (NEAs) or Foreign Educated Nurses: Nurses who completed their education outside Canada and who have English as a second language.

Practicum or clinical practice: a component of the refresher program the NEAs in this study attended. Nurses were placed in hospitals for actual observation and treatment of patients under the supervision of a clinical instructor.

Reaccreditation: process by which NEAs obtain a license to practice in Canada. The NEAs in this study had to: a) show proof of equivalency of education and work experience abroad; b) establish language proficiency (TOEFL 550, TSE 50); and c) pass the Canadian Nursing Examinations.

Refresher Programs: programs for registered nurses who have been away from practice for

a period of time, or for NEAs seeking reaccreditation and wish to familiarize themselves with nursing practices in Canada. These programs typically include theoretical and clinical practice components.

RNA: acronym I chose to refer to the professional association governing the standards and licensing of registered nurses. In Canada, each province has its own RNA. Reaccreditation requirements for NEAs may vary somewhat from province to province.

Chapter Two

Review of the Literature

In considering placing the question of reaccreditation of foreign trained nurses within a framework of existing research, I was drawn to areas of research from different fields, including language education, psychology, women's studies, history, and sociolinguistics. I have organized the review of the literature within four broad areas: 1) language socialization, 2) socio-cultural identity, 3) immigrants and work, and more specifically NEA reaccreditation, and 4) life histories. These areas are interconnected and often overlap. The literature review does not pretend to be exhaustive, its purpose is to provide a context for the current research.

2.1 Language Socialization

The theoretical framework of language socialization is particularly suited for the present study because it considers language learning as socially contextualized. Language socialization is a concept derived from psychology which accounts for the process by which children and other novices become competent members of social groups and the role of language in the process (Ochs, 1988; Schieffelin & Ochs, 1986a, 1986b).

The theory of language socialization seeks to account for the fundamental interconnectedness between learning a language and learning sociocultural practices (learning language and culture in a social context). Language learning is not a process that takes place in a vacuum, it happens when an individual interacts with his or her environment. Language socialization proposes that learning a language involves two simultaneous processes: gaining linguistic knowledge at the same time as gaining sociocultural knowledge. Meanings and functions of the language are culturally embedded, while values and morals as well as structures of knowledge and interpretations, are learned through language (Ochs, 1988).

Since the concept of language socialization emerged from research with children I will quickly review this literature to move on to consider studies on language socialization and adults and language socialization and ESL, which bear more directly on the current study.

2.1.1 Language Socialization and Children's Apprenticeship into Adulthood

The concept of language socialization developed from studies linking the development of higher mental functions of individuals through their participation in socially and culturally organized activities, where language takes on the role of mediating element or tool (Leont'ev, 1981; Vygotsky, 1978, 1987). The concept was originally used to describe the process by which children become competent members of social groups and the role of language in this process (Ochs, 1988; Schieffelin & Ochs 1986a, 1986b).

Some key terms to describe the process of language socialization are the "zone of proximal development" (Vygotsky, 1978, 1987) and "scaffolding" (Bruner, 1983). The zone of proximal development refers to the learning step between actual development and potential development which is negotiated by the child through problem solving under adult guidance or in collaboration with more capable peers. The concept of "scaffolding" refers to the way cultural activities are arranged in order to allow for learning to take place.

The literature on language socialization and children includes many studies of interactions between children and caregivers examining how, through these interactions, children acquire linguistic and cultural knowledge to communicate appropriately within a community. The groups studied include Samoan and white middle class American children (Ochs, 1988); Melanesian children in the Solomon Islands (Watson-Gegeo & Gegeo, 1986); white middle class, white working class and black working class American children (Heath, 1983, 1986); and Kaluli children (Schieffelin, 1986).

2.1.2 Language Socialization as Life Long Apprenticeship

Of more direct interest to the current study of foreign trained nurses is the literature on language socialization and adults. Although language socialization, as I mentioned above, initially focused on the process of children being socialized into the world of adults, the concept has also been applied to adults since "individuals have the potential to modify linguistic and socio-cultural knowledge throughout the course of their life spans." (Ochs, 1990, p. 289). Lave and Wenger (1991), for example, in reviewing accounts of adult apprenticeship, including studies of Yucatec Mayan midwifes (Jordan, 1989) and butchers in U.S. supermarkets (Marshall, 1972) identified a process analogous to the "zone of proximal development" which they termed "legitimate peripheral participation" by which "newcomers become part of a community of practice." (p.29)

2.1.3 Language Socialization and ESL

The concept of language socialization is particularly fruitful in the field of second language acquisition and settlement since it helps describe the complex process of gaining new linguistic and socio-cultural knowledge newcomers engage in as they take on new roles in changing socio-cultural environments. Research in this area has ranged from broad ethnographic studies of classroom culture and the interplay of socio-cultural and linguistic contexts, to studies with a sharper focus on specific elements of language socialization. Saville-Troike (1989) explored the question of what people need to know in order to communicate appropriately in a community, and how they acquire such knowledge.

Willett's (1995) study of four ESL first graders illustrates how the socio-cultural context of classroom, school, community and wider society shaped the ESL children's identities, social interactions, ideologies and L2 development. Casanave (1992) and Losey (1995) also looked at

how classroom and social context influence students' interaction and participation, but for adults enrolled in graduate school and at a community college respectively.

Poole (1992) studied, more specifically, teacher-student interactions in two beginning-level university ESL classes, uncovering parallels between teacher's accommodations to students' language and caregiver accommodation described by Schieffelin and Ochs (1986b). Mohan and Smith's study (1992) of a group of Chinese LEP students looked at how their success in graduate school was attributable to the type of support they received in adult education courses through classroom activities that were carefully scaffolded. Nishizawa (1997) also considered language socialization in the classroom, in this case, for NS and NNS enrolled in first year English classes and its adjunct course for the NNSs. The study found evidence that both groups were socialized into the language and the practice of a new socio-cultural site, the first year college English class. Furthermore, the adjunct course for NNSs provided scaffolding for language socialization in the English literature class. Morita (1996) focused on a particular classroom task, oral presentation tasks, in graduate school, an example of graduate students' language socialization.

Finally, evidence was found that language socialization does not necessarily need to take place between an expert and a novice, but can occur among peers. Donato (1994) found that students engaged in scaffolding in their oral interactions for a French language class.

The theory of language socialization, which considers how novices become competent members of their social group and the role of language in this process, sits well with the subject of this study, the apprenticing of foreign educated nurses into professional practices in Canada through L2 learning. Related to the concept of language socialization, I will also consider some of the literature on socio-cultural identity and second language acquisition.

2.2 Socio-cultural Identity

One of the guiding hypothesis for this study is that in the process of re-accreditation, foreign trained nurses, experience a shift in social identity and that this shift has some significance in terms of their language acquisition. I will review in some detail the theoretical framework used by Norton's (1997) work since it appears to be particularly fruitful for this study and then proceed to briefly review studies related to identity and L2.

Norton (1997) has identified some common themes in the literature on social identity. The common understandings for researchers are that identity is complex, multifaceted and contradictory; and that identity is dynamic across time and place; identity constructs and is constructed by language; identity construction must be seen within larger social processes which are marked by relations of power that can be coercive or collaborative.

Norton (1997) references her work on L2 learners and identity by looking at identity and its relationship to power. She identifies five major strands connecting identity to power. First, identity is related to desire, to material resources in society. It does not answer the question of "Who am I" but rather "What can I do" (West, 1992). Second, identity is connected to symbolic power (Bordieu, 1977). This concept looks at communication within a network of social relationships, social relationships that are unequal. Given this context, competence should include consideration about the "right to speak" and the "power to impose reception". Third, identity is considered as an investment. Concepts of motivation and personality in explaining the learner's relationship to the target language are replaced by considerations of the learne complex history and multiple desires connecting her to the language she is learning. The investment made in the target language is an investment in the learner's social identity which changes across time and space. The fourth concept, subjectivity, comes from a feminist post-structuralist perspective. It integrates language, individual experience and social power. Individual agency and the importance of language is given more emphasis. Subjectivity considers

the multiple non-unitary nature of the subject. Subjectivity is seen as a site of struggle and as changing over time. A person takes up different subject positions depending on the social site and on the relations of power. The subject is not passive, it is subject of and subject to relations of power within a site, community, society. Subjectivity and language are mutually constitutive. The fifth and final strand considers relations of power as collaborative rather than coercive (Cummins, 1996). Power is not fixed, it can be mutually generated in interpersonal and inter-group relations. It is additive not subtractive; it is created with others rather than imposed on others.

The study of social and cultural identity of L2 learners is a relatively recent field of interest for research (Duff & Uchida, 1997; Goldstein, 1995; Leung, Harris & Rampton, 1997; Morgan, 1997; Norton Pierce, 1995; Thesen, 1997). Norton Pierce in a longitudinal study of immigrant women in Canada views the learner's interest in L2 acquisition as an investment in that person's social identity. This investment changes across time and space and is socially and historically constructed, reflecting the learner's multiple desires rather than arising from personality or motivation.

Goldstein (1995) in an ethnographic study of Portuguese-speaking factory workers highlighted the importance of identity and broad socio-economic factors affecting learner interest in English classes. The use of English on the shop floor may jeopardize friendship and support networks built around ethnic identity through language choice. This in turn would affect the interest of workers in acquiring English and enrolling in language classes.

Duff and Uchida (1997) combine concepts of language socialization and socio-cultural identity in an ethnographic study of EFL teachers in Japan to look at how their socio-cultural identity is related to their teaching practice. The study points to the complexities of socio-cultural identity and practice and suggests that socio-cultural identity develops along two lines, a biographical/professional one and a contextual basis.

Morgan (1997) points to the importance of considering issues of social identity in L2 pedagogy as a means for social action and transformation. Identity is socially constructed and potentially transformed through social action. By contextualizing language features such as sentence-level stress and intonation, highlighting their strategic value as resources that may be used to challenge power relations based on gender and ethnicity, students can negotiate their identity in their new social setting.

Thesen's work (1997) focuses on biographical interviews of first year students in South African universities in the process of acquiring academic literacy. Her study points to the discrepancy between students' own account of their identity as opposed to the identities they are assigned as well as the implications of labeling in the way students are taught. The fixed identity categories applied to social groupings, such as race, gender, ethnicity and language overlook the individuals' own perceptions as they move through different discourses. She proposes that existing frameworks of critical literacy need to take into account students' own emergent identities as agents, beyond the labels of insider, colonized or outsider.

More research highlighting the inextricability of social identity and language use is reported by Leung et al. (1997) based in a study of high school students in England. They also point to the importance of taking into account learners as active agents of their own identities and consider how definitions of identity are often in contradiction with the definitions imposed by those engaged in ESL pedagogy. They propose that fixed concepts of ethnicity and language are no longer valid given the complexity of current multicultural societies. They see the label of native, non-native as being problematic and suggest that considering instead language expertise, language inheritance and language affiliation as more valid.

To summarize, identity has become an important factor to consider when looking at language learners and their process of acquiring a new language. Identity is seen as being multi-fasceted, socially and historically constructed and changing over time and place. An awareness of

identity is seen as being empowering to students; as being an important factor to contribute to the understanding of why and how learners choose to learn or use a language given different circumstances.

2.3 Immigrants and Work

In this section I will review literature related to the settlement process of foreign educated nurses. I will start by looking at studies addressing the issue of work and training for immigrant women and professionals, to move on to ESL programs with an occupational focus in general and the more specific area of ESL and nursing education.

2.3.1 Work and Training for Immigrant Women

In this section I will briefly highlight some themes emerging from literature relating to immigrant women, employment, language and vocational training programs since this study looks at the case of five women nurses, and the issues they face in settlement are particular to women. In other cases, such as in the areas of training programs and reaccreditation, I have included studies that are not gender specific.

Immigrant women make an important contribution to the nation's economy and to their family's income (Beach & Worswick, 1993; Ng & Estable, 1987). Immigrant women within the workforce are in a disadvantaged position by virtue of the traditional roles assigned to them and their gender. Studies point to immigrant women as having to put in a "double day" (Beach & Worswick, Ng & Estable,) at the work-site and at home. They also describe the conflict women face between taking available employment that is poorly paid and below their abilities and participating in language or training programs that would lead to a better job (Burnaby, 1992; Rockhill & Tomic, 1994). Often women delay plans for further education for what has been termed as the "family investment strategy hypothesis" (Beach & Worswick, 1993; Baker &

Benjamin, 1994); whereby a woman gives priority to her spouse's education and further training so that he will be the first one to find better employment.

Although immigrant women have a higher rate of involvement in the workforce than their Canadian-born counterparts (Ng & Estable, 1987) they receive the lower monetary remuneration for their work. Studies point to several reasons for this situation. A femi□□□□ perspective points to the gendered nature of the division of labour where women and in particular, immigrant women are relegated to poorly paid work such as domestic work (Cohen, 1987) and office cleaning work (Neale & Neale, 1987). Studies point to the fact that male immigrants with equivalent educational and language proficiency levels have access to higher paying jobs in the trades (Beach & Worswick, 1993). A critical perspective points to economics, politics and racism as the main factors responsible for maintaining immigrant women in a disadvantaged position. Sauvé (1990), in a discussion on socio-political concerns of ESL in Canada, presents the case of three women needing literacy skills. She prefaces her discussion stating that Canadians' assumptions about the role of immigrants in our society is that they will take jobs other Canadians do not want. Low paying positions are occupied mainly by immigrants with little formal education and poor English language skills. Their lack of language skills affects their ability to be informed citizens able to express opinions, make a case for their needs and be a political force. Sauvé also suggests that the concept of a harmonious multicultural Canada is in fact a myth and that this society's racism plays an important part in maintaining inequities in the workplace.

Access to adequate education is presented in the literature as a way to provide equal opportunities for immigrants. Ramkhalwansingh (1981) adds an interesting point to the case for education by stating that employment positions open to most immigrants are such that they provide little opportunity for the use or acquisition of English on the job. Boyd (1992) in linking

knowledge of the English language to socio-economic status, calls for extensive provision of language training as well as literacy programs and skill retraining programs.

Other related literature focuses on the different barriers faced by immigrant women in accessing vocational and language training such as lack of information and referral regarding suitable programs (Burnaby, 1992; Doherty, 1992); scarcity of programs designed specifically for women (Cumming & Gill, 1992; Rockhill & Tomic 1994) including the provision of special services such as childcare (Boyd, 1992), long wait lists, few seats available and restrictive eligibility requirements (Doherty 1992). Butterwick and Ndunda (1996) make reference to a report to the Task Force on Transition into Employment and the Canadian Labour Force Development Board (1994) which analyzed several training programs across Canada and concluded that characteristics of effective programs included some of the points addressing issues and barriers mentioned above: language training of sufficient duration to ensure employment in more than low-waged jobs, free, on-site childcare, on-the-job-training to provide participants with Canadian work experience, and in addition, assessment and recognition of foreign credentials.

While recognizing the need to address systemic and structural barriers to training and employment for immigrants, Butterwick and Ndunda (1996) suggest that rather than training to "fix" the equity group, what might also be required, is training to change attitudes of our society at large such as racism. They also caution against the belief that training is the panacea for all immigrants seeking to better their employment status, indicating that broader economic conditions account for a lack of jobs paying a salary sufficient to maintain an adequate standard of living. Demand for ESL classes is high when the economy shows a decrease in employment prospects. If semi-skilled manufacturing jobs are not available and if "better" English does not help in securing the jobs that do exist, workers may look for further study and retraining options (Belfiore, 1992).

To summarize, immigrant women make an important contribution to the economy at the national and family levels. Generally speaking, they are employed in occupations with low socio-economic status. This is due to a complex set of factors including barriers due to gender, race, lack of knowledge of English, training in better paying occupations and broad economic and job market conditions. Women also face particular set of barriers to training. Broad economic factors may determine employment status of immigrant women.

2.3.2 Work and Training for Immigrant Professionals

Issues outlined above are relevant to the group of nurses included in this study by virtue of the fact that they are immigrants and women. Given their educational background and occupation, they also belong to a narrower category of migrants, that of professionals. In this section of the literature review I will include works that focus on similar issues as in the previous section but in reference to professionals. The literature I reviewed takes a look at Canada's immigration policy as it relates to professionals (Bolaria, 1992; Li, 1992), immigrant professionals and their employment status compared to that of Canadian-born professionals (McDade, 1988), barriers they encounter and the human costs involved (Belfiore, 1992; Cumming, 1989; McDade, 1988; Maraj, 1996; Tomic & Trumper, 1992).

Li (1992) and Bolaria (1992) provide a historical perspective on immigration of professionals and describe how developments in Canada's immigration policy have been shaped by economic forces. Li examines the immigration of professional and technical workers to Canada since the fifties and explains how the country has become dependent on this type of immigration as an important means to supplement its skilled labour supply "as a result of economic growth and the loss of skilled labour to the United States" (p. 160). Bolaria looks at the immigration of professionals in Canada as part of the development of global capitalism and the internationalization of labour. Global economic disparities allow core countries such as Canada

and the United States to access international labour pools and to regulate the flow of international labour through immigration laws. Thus, changes in the Immigration Act in the 60s which stressed educational and technical qualifications by means of the point system, obeyed to labour market requirements of demand and supply rather than to a "softening" of previous criteria barring applicants with "undesirable attributes" such as place of origin, racial background and cultural differences. The Non-Immigrant Employment Authorization Program, introduced in 1975, is a further response to the need for qualified labour. Although usually associated with the supply of seasonal farm labour, half of the authorizations are granted to professionals; "like the manual low-cost labour, professional-technical high-cost labour is also rendered as a migratory, non-citizen and peripherized work force." (pp. 226-227). Bolaria points to the cultural hegemony of the Western educational system as a means for easier flow of international labour, since most professionals in developing countries have been educated in systems patterned after systems in the developed world. Nonetheless, this does not ensure recognition of qualifications; self-regulating professional associations may impose additional training and requirements, affecting the career and mobility of the foreign trained professional. The marginal positioning of immigrant and migrant professionals, occupying the lowest level of professional hierarchies in places where their Canadian-born counterparts are unwilling to work, allows for supplementing rather than replacing the indigenous professionals.

Several studies based on statistical data, provide evidence of the disparity in career mobility between immigrant and Canadian-born professionals. Boyd (1985) found that education translated into higher occupational status for Canadian-born males than for immigrant males; while foreign-born females occupy the lowest status. Interestingly, twice as many immigrant women compared to Canadian-born women have some university education (Grindstaff & Trovato, 1985) nonetheless they are less likely (by a ratio of two to three) to hold professional jobs. Based on interviews with 80 immigrants, the report by Fernando and Prasad (1986)

prepared for the Affiliation of Multicultural Societies and Service Agencies of B.C. (AMSSA) provides further evidence of under-employment and unemployment among persons with professional and technical backgrounds. All these studies suggest that non-recognition of qualifications and Canadian work experience requirements by employers explain the disadvantaged position of immigrant professionals.

The Royal Commission Report on Equality and Employment headed by judge Abella (1984) identified lack of adequate language training and lack of information about accreditation as barriers for the successful social, political and economic integration of immigrant professionals into Canadian society. The reports states that:

> Very few advanced courses and almost no vocationally oriented ones are available. This means few opportunities exist for skilled or professional immigrants to acquire the level of expertise needed for employment in their field of specialty. An extended program should be available for these immigrants, some of whom need advanced levels of English/French to meet trades licensing requirements.
>
> (p. 157)

The commission recommends that time limitations for courses be replaced with "desired competency level" goals. Other recommendations include the provision of information prior to immigration regarding employment and accreditation, as well as the creation of an agency to provide counseling services, advice on how to pursue professional accreditation and language referral services. These recommendations have not been put in practice.

McDade (1988) examines the barriers to recognition of credentials in the trades and professions. She concludes that these barriers are largely attributable to subjective methods of evaluation, "while some professions have devised evaluation exams or established review panels as a means of assessing the academic preparation of candidates for certification, others refuse to

recognize any education obtained outside Canada." (p. vii) Assistance for professionals is limited to information provided by immigrant serving agencies or by academic advisors at post-secondary institutions. This study cites examples of legal redress sought before provincial human rights commissions by professionals unable to achieve recognition of foreign credentials, including the Prince Edward Island case of a nurse educated in the Philippines who had practiced as a registered nurse elsewhere in Canada for sixteen years but was refused a license by the Prince Edward Island Nurses Association. "The merits of the case were never discussed publicly because an undisclosed settlement between the parties was reached before public hearings could be convened" (p. 22).

The 1989 Task Force on Access to Professions and Trades in Ontario was charged with reviewing all rules and practices affecting entry to professions and trades by foreign-trained individuals. The detailed report (Cumming,1989) makes recommendations in the areas of prior learning assessment, language and licensure testing and language training and occupational retraining. The task force proposes the creation of an independent agency to assess equivalencies and ensure standardization of criteria. For testing, it suggests that the licensure examinations be required of all candidates qualified to write them and that no additional testing be required for foreign-trained applicants. Test development should be standardized and developed according to recognized professional standards including language at a level appropriate for the profession and devoid of cultural bias. A cautionary note is struck with respect to the reliance on licensure examination to screen for language proficiency, since the level of language proficiency required to write the exam may not correspond to the language needed to be a competent member of the profession. The task force viewed the creation of specific language tests as ideal and recommends abandoning the use of standardized language tests such as the TOEFL, TSE and MTB given the arbitrariness of cut-off scores; the fact that they test discrete points rather than integrated skills; "candidates are tested against a standard of fluency that bears little relationship to the language

needs of the work they plan to undertake" (p. 196). The major stumbling-block for foreign trained professionals in training and retraining is that programs are not available to all that need them. In terms of language training the report recommends programs focusing on professional qualifications and occupational specific language at an appropriate level.

Another area of the literature on immigrant professionals, explores the human cost associated with unemployment and under-employment (Belfiore, 1993; Maraj, 1996; Tomic & Trumper, 1992). Belfiore's research, conducted in several industrial cities in Ontario, focused on ESL students who were displaced workers. The aim of the program was to support students and instructors and was accompanied by the development of classroom materials, information on resources and training for instructors on issues of labour adjustment. The study included a survey of 34 community classes, and in-depth interviews conducted with 20 students. Although not specifically directed at professionals, the study reports that issues of unemployment and underemployment of highly skilled and professional workers was of paramount concern according to teachers in the programs. Of the 20 students interviewed, none had worked in jobs that recognized their previous training and experience. Belfiore emphasizes the psychological cost to the professional, "loss, frustration, shame and resignation to a 'wasted' life are at the other end of immigration and access policies that encourage and welcome the skilled immigrant but offer few avenues to successful professional integration." (p.12)

Maraj (1996) focuses more specifically on the psychological impact of non-accreditation by examining the economic and affective impact of occupational dislocation amongst foreign educated immigrant professionals unable to gain accreditation in their field in Canada. Data was collected through semi-structured interviews of six participants in the study. The results indicate that inability to gain accreditation and subsequent employment in the professional field has a greater affective than economic impact on this group.

Tomic and Trumper (1992), sociology professors, recount their personal experience as Chilean political refugees arriving in Canada with a university education. They describe the process of devaluation they underwent as they were denied access to language training; they lacked knowledge of their rights and were streamed into unskilled poorly paid work. They intimate that the process of devaluation may continue even after reestablishing oneself as professional "will we ever overcome the power of the dominant discourse or do accent and language (and, of course, colour) retain their ability to disempower" (p. 179).

To summarize, the literature on immigrant professionals indicates that Canada relies on foreign trained individuals to supply its need for labour in the high-skill fields. Within this field, immigrants hold a marginalized, disadvantaged position vis-a vis their Canadian-born counterparts. Furthermore, gaining entrance into professional occupations is not a given, immigrants face many obstacles in this process including recognition of credentials, licensure testing. Language proficiency testing, lack of information, lack of appropriate training and retraining programs in language and specific occupations. The psychological costs immigrant professionals face by being devalued is high. In the next section of the literature review, I will examine studies that look at particular characteristics of ESL training programs related to work.

2.3.3 ESL Training Programs for Work

The nurses in this study participated in two training programs with components in nursing and ESL to prepare them to write the licensure exam in nursing and to work as nurses. The existing literature does not address reaccreditation of foreign educated nurses, therefore, I will briefly review literature related to ESL training programs for work and in the next section, I will report on literature regarding nursing programs for ESL students.

The review of literature on ESL and work presents examples from a range of occupational areas such as printing (Stapp, 1998), manufacturing (Goldstein, 1994), the oil

industry (Holliday, 1995), nursing assistants and health care aides (Vivian, 1984; Wilson, 1998; Wong, 1998), to name a few; however, there is a dearth of accounts of collaboration between the disciplines of ESL and Nursing. Articles on nursing programs and ESL students come from nursing faculty.

The complexities and challenges of combining language and content for work is central and a recurring theme in the literature, from assessing the needs of stakeholders and program design (Goldstein, 1993, 1994; Holliday, 1995; Prince, 1984), to program delivery (Platt, 1993; Stapp, 1998) and evaluation (Wilson, 1998). Platt's research on ESL/content teacher collaboration highlights some of the underlying issues in this area. Through interviews and classroom observation of vocational and vocational ESL teachers, Platt identified philosophical and professional orientation, attitudes, authority in the school and integration of knowledge as key points of tension in combined training programs. Following Swales' (1985) description of language instructors' philosophical orientation, Platt indicates that the vocational instructor is far more concerned with external accountability and occupational standards than the language instructor. Language instructors, on the other hand, espouse a "caring and sharing" (p. 146) methodology and often dedicate a great deal of energy into providing other support services for students and into acting as advocates. Platt suggests that these concerns may be a factor in preventing language instructors from taking the appropriate steps to improve language instruction which often focuses on sentence level and formal aspects of the language rather than on the more complex discourse level and communicative language. Another interesting finding from the study relates to the integration of knowledge between ESL and vocational faculty. Practice showed this process to be unidirectional, language instructors learned about the vocational field but the vocational colleagues were not interested in the knowledge resources of the language instructor; "vocational teachers interviewed did not appear to value the knowledge of their language teaching peers, that being pedagogical and conceptual. They either learned from experience how

to teach the students, or simply did not teach them at all." (p. 154) Platt sees the role of the language instructor as developing programs teaching the discourse students need for the classroom and for their occupation and to be involved in ongoing professional development for the content colleagues in teaching students with limited English proficiency.

2.3.4 ESL and Nursing Education

The literature on nursing and the field of ESL includes studies regarding predictors for success or failure (Mills, Becker, Sampel & Pohlman, 1992; Safian-Rush & Belock, 1988), student retention (Jalili-Grenier & Chase, 1997), ways of supporting ESL nursing students in the classroom and matters of methodology in teaching nursing students who have English as a Second Language (Gay, Edgil & Stullenbarger, 1993; Phillips & Hartley, 1990) and adjustments to reduce cultural bias in nursing examinations, (Klisch, 1994).

The study by Safian-Rush and Belock (1988) was initially prompted by high attrition rates and low passing rates on the state licensing exam for nursing in Florida. The school of nursing studied the records of graduates and it appeared that students with a foreign background had the most failures in the program and on the licensing examination as well as the lowest CLAST scores. While this quantitative study was able to establish a positive correlation between CLAST results and academic achievement, and age and academic achievement; due to the small sample, it was not able to determine a correlation with the variable regarding student foreign background.

Mills et al. (1992) also looked at predictors of successful performance. As well as grade point average and gender, they found that foreign education was a significant factor. By the end of the second semester, American-educated nursing students had a 4.5 better chance of passing than their foreign-educated counterparts.

Jalili-Grenier and Chase (1997) focused on comparing perceptions of ESL students, non-ESL students and faculty regarding learning difficulties and helpfulness of specific learning activities. The study was conducted through a questionnaire distributed to students and faculty at the University of British Columbia/Vancouver Hospital Nursing Programme. In the area of perceived learning difficulties, although there were some differences between ESL and Non-ESL students, the difference in perception was significantly higher between ESL students and faculty. Faculty rated learning difficulties higher and learning activities contributing to learning lower than did ESL students. While ESL students identified asking questions in laboratories, the first year clinical and English courses as presenting difficulties, faculty identified, as well as the clinical experience, asking questions not only in the laboratory but in various settings as well as studying required readings, writing exams, term papers, listening and taking notes, participating in seminars and tutorials, conversations and doing assignments. Perceptions also differed in rating effectiveness of ways to learn English. While faculty rated ESL classes high, ESL students rated them low, giving preference to learning language in university classes, conversation with English speakers, reading English books and course materials. Another finding of the study was that 80% of the faculty identified the need for assistance in working with ESL students. The four choices presented in the questionnaire were rated high (78-100%). Interestingly, "workshops on effective instructional techniques for ESL students" and "academic support programmes for students" were rated higher than "collaboration with ESL specialists". The authors conclude with recommendations to establish support programs for ESL students, particularly for the clinical experience; learning activities stimulating more than one sense; forums and workshops to close the gap between the disparate perceptions; and more research in areas such as the relationship between language and culture.

Gay et al. (1993) report on their experience as educators in a graduate nursing program for foreign students who have English as a second language at the University of Alabama School

of Nursing. The authors describe challenges in teaching students with limited language proficiency and report on how they have dealt with these challenges by sharing personal knowledge in working on these programs. The discussion on language and communication is organized according to the four skill areas: speaking, listening, reading and writing. According to the authors, educators and students differ in their perceptions regarding spoken communication; while students feel that their spoken English is deficient, faculty reports that comprehension is not a problem. On the other hand, instructors report as problematic, issues such as students speaking very softly, paying special deference to the teacher, not participating in class discussion and being reluctant to ask for clarification. Faculty members have used other students as mentors or translators to check for comprehension. The authors also report that "students have enrolled for special conversational English classes offered by the university, and others have attended English-speaking classes offered by a church near the campus." (p. 106). Listening is not perceived as problematic, educators report that students take copious notes or make use of a tape recorder for lectures. Reading is seen as the strongest language skill students posses coming into the program. Once in the program, they meet with faculty and later on with local students to discuss the readings and check for comprehension. The authors do not give details as to whether the meetings are an informal or a formal part of the program. Writing is seen as deficient. The authors focus on syntax, giving as examples errors in subject-verb agreement and use of articles. They are also concerned about the use of references and paraphrasing. These concerns are addressed by referring students to an English skills laboratory, by instructors working one-on-one with students, editing multiple drafts, allowing more time for papers and examinations as well as giving the option of writing examinations in native language depending on the availability of translators. The article concludes by calling for research in the area.

Phillips and Hartley (1990) also write about the challenges of teaching nursing students with ESL and look at interventions to assist students in the four language skills. While also

commenting on characteristics of ESL nursing students they observed in their teaching, rather than reporting on strategies emerging from practice as in Gay et al., they propose applying knowledge from non-nursing studies in ESL, ESP and EAP to the specific field of nursing.

Unlike the previous article, these authors estimate that reading and listening are the two most challenging language skills for students. In reading, nursing ESL students face difficulties with speed and recall of complex and lengthy materials. As well, reading is crucial for nursing tests which usually have time limits and involve processing problems containing subtle linguistic nuances. The authors also mention that foreign trained students may be unfamiliar with standardized test formats. The authors' recommendations in the area of reading is to employ computer assisted instruction.

In listening, nursing students are challenged with new concepts and vocabulary. While recommendations also include the use of a tape recorder for lectures, unlike the previous authors, they perceive ESL students as being poor note-takers that would benefit from a course in note-taking skills as well as from the use of visuals by the instructor.

Communication anxiety is seen as a major factor affecting students' ability to participate in class and to learn. The authors recommend setting up study groups, "buddy" systems and other activities which bring together ESL and native speakers in a non-threatening way. For pronunciation, students should be referred to speech pathologists or audiologists. Clinical practice is seen as an opportunity for language acquisition within a natural, content laden environment. An interesting point is made regarding the student as a linguistic resource; "ESL students may need instructor support in refusing requests for translator duties from other students and staff if those duties jeopardize the completion of their own clinical assignment" (p. 31).

In writing, according to the authors, lexical errors were reported by professors as being most serious. Their recommendations are similar to the previous article in looking at writing as a process, facilitating revisions and making use of a language lab. They specify that the writing lab

should work with content materials to keep students' interest engaged and to increase their knowledge of the language specific to their field. The article concludes with a consideration of learning styles. The authors point out that there is a good fit between ESL students' reported preferred learning styles, kinesthetic-tactile and nursing with its many laboratory and clinical experiences. Although students do not favour group learning, the authors recommend the inclusion of group activities for their value in learning interpersonal and leadership skills.

Klisch (1994) presents guidelines for reducing bias in nursing examinations. Her recommendations are directed to faculty in nursing programs. Given the lack of published works in this field, the article is largely based on informal telephone interviews with faculty in the fields of nursing, cultural diversity, education, psychology and sociology. Klisch focuses on structural bias, test items that are poorly written; and cultural bias, items that contain references to a particular culture and generally receive an incorrect answer from students in a particular cultural group. The recommendations include working collaboratively on test-item editing given the time, sensitivity and skill required in this process. The article concludes with a discussion of whether ESL students should be given extended test time to allow for slower reading and writing.

To summarize, there is a dearth of literature on foreign educated nurses seeking reaccreditation, while the literature in the area of Nursing and ESL students is scant and recent. The existing literature presents ESL nursing students as having more difficulties in their program of studies and being less likely to complete the program as well as pass the licensing exam than their non-ESL counterparts. Cognizant of the growing number of ESL students in nursing, some studies are concerned with how to ensure student success and maintain standards by identifying assessment tools to determine what minimum requirements ESL students should fulfill in order to be accepted into nursing programs. Other studies focus on changing evaluation tools that might prejudice ESL students' success because of cultural bias. Another area of the literature focuses on how to support ESL students in their nursing programs. While there is a recognition for special

considerations in the teaching of ESL nursing students there seems to be little collaboration between ESL and nursing faculty. The literature also indicates there is a significant discrepancy between student and faculty perceptions of areas of difficulty and activities helpful in learning. Finally, ESL nursing students in the literature are portrayed in different ways, at times they are presented as challenges for the nursing teaching profession; an inevitable, less than desirable reality given falling enrollment in nursing schools and an increased demand for nurses; at other times they are seen as an asset to the profession given the growing diversity of the population at large (Klisch, 1994).

2.4 Life Histories

This study is based on the life histories of five nurses. In this section of the literature review, I will review literature on life histories relating to women, professionals, language and identity. I will leave methodological issues in life histories for the next chapter.

Life stories have been used to study women who have a professional background (Ayers, 1980; Casey, 1993; Duff & Uchida, 1997; Etter-Lewis, 1991; Lawless, 1991; Middleton, 1993). Many of these studies have focused on women teachers. Duff and Uchida used life stories along with journal entries and classroom observations as part of an ethnographic case study of three EFL teachers in Japan (three women and one man) to explore teachers' sociocultural identities and practices over time. Ayers also used life stories and participant observations in a study of preschool teachers resulting in "portraits" of teachers. The emphasis in this work is on the co-constructing of the life-narratives which he also calls autobiographies. Ayers as well as Duff and Uchida point out that the process of constructing life histories is a reflective process for teachers which leads to transformations in practice. Middleton uses life histories to examine her own as well as other teachers' lives from a feminist, critical stance and to explore the marginality of women and their "cultural capital". Finally, Casey's extensive study of life histories of activist

women teachers focuses on the relation between the teachers' discourse and that of the dominant cultures surrounding them.

Through life histories and later discussion sessions with female ministers, Lawless (1991) discovers the difficulties these women have in formulating a life story that takes into account all the different aspects of their lives in the professional and personal realms, "there is not, at the present time, a perceived tradition of what a good professional woman's life story sounds like" (p.57), and suggests reciprocal ethnography as an exploration of this area of study.

Etter-Lewis (1991) is interested in issues of race within a feminist approach. Her narratives of older black women professionals focused on how their unique life experiences influence how they tell their stories. Oral narratives are seen as a vehicle to reflect a multiplicity of experiences and world-views, "(black women) do not have the privilege of *only* being women, or of *only* being black Americans in particular situations. Instead, their roles are melded. Usually they must wear both hats at the same time." (p.56)

As well as the life stories on women I reviewed above, another group of life stories that is relevant to my study present lives of individuals who experienced some form of "border crossing". Kouritzen's (1997) research explores the process of linguistic border crossing through the loss of a first language. The study explores the meaning of first language loss for 21 cases and concludes that it has had significant negative consequences for the person's family life, work life, school achievement and cultural identity.

Harper (1994) limited her study to the life history of Mira, a Lebanese refugee in her process of culture learning and adaptation. The study revealed that Mira had engaged in transformative learning, that she was an active agent in learning Canadian culture; that in forging her new identity she held on to Lebanese values and a sense of ethnic identity. She placed herself in the margins of both Canadian and Lebanese culture, resisting aspect of both.

Border crossings or reentry adaptation for three males returning to Canada after working abroad, is described in Crystal's (1997) research within the field of counseling psychology. The act of self-narrative is seen as an act of defining identity. The experience of border-crossing is seen as a "quest for personhood" and the process of telling a life history is seen as constructing an identity, "when a person recounts the story of their lives ... they are theoretically shaping a personal narrative, an identity." (p. 31)

Finally, the study by Belfiore (1993), already mentioned under a previous section on immigrants, includes oral histories for 20 displaced workers, narrating their work life experiences before and after arriving in Canada "through these personal testimonies, we hope to give depth and humanity to the data - to find commonalties in the experiences of displaced workers that provide an avenue for empathy and action on the part of ESL educators and administrators." (p.3)

In summary, life histories have been used to lend voice to those that are marginalized in society, to explore how the narrator perceives processes and experiences in her life. Life histories are seen as both revealing and constructing a person's sense of self.

2.5 Identifying a Gap in the Literature

In reviewing the literature I found various elements, topics and issues that are relevant to this study. These elements include: how language is acquired within a particular socio-cultural context (language can not be learned separate from culture and culture can not be learned separate from language); how in the process of learning a language and a culture, identities are constructed and re-constructed; how an understanding of identity is an important aspect of students to take into account by individuals engaged in the field of language education; the many barriers faced by immigrant women and professionals in settlement; the challenges faced by nursing programs in preparing ESL nurses and the

complexities of combining the teaching of language and content that are occupation-specific; and finally, the use of life stories related to women, immigrants, language and identity.

However, I found no literature on the process of reaccreditation for foreign educated nurses. The literature I found helped me gain some background and gave shape and focus to my research. The purpose of this study is to present the meanings and understandings that nurses bring to the process of reaccreditation, specifically, how they are transformed in the process of learning the language and culture of nursing in Canada.

Chapter Three

Methodology

In this chapter I will explain the rationale for selecting the methodology for this study, and I will describe participant selection, data collection, data analysis, as well as the limitations of the study.

3.1 Life Stories as Method

Life history as a research approach has been used throughout the social sciences. Also known as oral history, case study, in-depth life history interview, biographical interview, and personal narrative (Reinharz, 1992), a life history is an autobiography that has been prompted by someone else. It is typically generated through interviews. Although similar to an interview, rather than focusing on a particular experience or phenomenon, life histories take in a wide range of topics from a person's past. The topic is placed within a chronological or developmental framework. Referring to Dollard's (1935) classic work, Marshall and Rossman (1995) define life histories as "a deliberate attempt to define growth of a person in a cultural milieu and to make theoretical sense of it." (p. 88) This study examines the growth of five nurses in different cultural milieus. Oral life history is particularly well suited to give an insider's view of a culture (Edgerton & Langness, 1974), in this case the culture of foreign educated nurses. The intent of my research question is to describe and interpret an aspect of the culture of foreign educated nurses. I would like to describe and analyze the practices, beliefs and knowledge of a group of people, in this case, foreign educated nurses seeking reaccreditation. I am seeking an interpretation that will incorporate the symbolic meanings that the participants ascribe to the

questions of language, nursing practices and ongoing patterns of interaction related to these meanings.

Taylor and Bogdan (1984) define life histories as describing "the important events and experiences in a person's life" (p. 143) through the person's own feelings, views and perspectives. This study will look at the development of nurses through the process of reaccreditation, a significant event in their lives. Studying the process of how nurses re-enter a profession within a new culture and language fits within the scope of life history which "is often an account of how a new person enters a group and becomes an adult capable of meeting the traditional expectations of that society." (Marshall & Rossman,1995, p. 88) Thus, the use of life histories is particularly well suited to this study since it explores issues of identity, language socialization and occupations.

This study also fits within the tradition of feminist life history research. According to Sherna Gluck, women's oral history is a feminist encounter because "it creates new material about women, validates women's experience, enhances communication among women, discovers women's roots, and develops a previously denied sense of continuity" (quoted in Reinharz, 1992 p. 126). Feminist and critical theory intersect in life histories by lending voice to those who have been marginalized either because of gender, race, or class. The voices of the five nurses come from the margins of being women, being visible or audible minorities and from a position of disparity as professionals who are immigrants compared to their Canadian-born counterparts (Bolaria, 1992; Boyd, 1985; Li, 1992; McDade, 1988; Tomic & Trumper, 1992)

The study has limitations in scope. I am interested in one aspect of the reaccreditation process for NEAs, the relationship between learning a language and a cultural practice (that of nursing) and changes in nursing identity. The purpose of the study is not, for example, to evaluate the RNA's policy for reaccreditation or the effectiveness of programs preparing

nurses for reaccreditation. Life stories, is the appropriate method for the research question because I want to look at matters of social action for nurses, what takes place in seeking reaccreditation, from the participants' perspective and what meanings nurses attach to the process.

3.2 Participant Selection

Criteria of feasibility and suitability guided the selection of appropriate participants. In terms of feasibility, the group of nurses most readily accessible for the study, were participants who took part in a nine-month, government funded, training program combining ESL classes, TOEFL/TSE preparation and an orientation to nursing in Canada using a curriculum and materials developed by the RNA. The program was offered by the non-profit society for which I had been working for three years as project manager for various programs, including the one in this study. The Immigrant Serving Agency (ISA) is one of the largest and longest standing immigrant agencies in the country.

Taking into account the principle of suitability, the selection was further narrowed to graduates from the program who had continued with the process of reaccreditation by enrolling in a more advanced Refresher program offered by a local community college. Of the fifteen participants in the program, three enrolled in the Refresher program immediately after completing the ISA program, while another four enrolled the following year.

Throughout the year and a half after the program finished and before I decided to work with graduates from the program in this study, I had been in touch with some of the participants. I met one of them at the college where I currently teach and where she was taking a course in office administration. She had decided to change her career path after

considering that the needs of her young family and the on-call schedule nursing would demand were in conflict. Other former participants had called me to check if I would serve as referee for jobs they were applying. The participants themselves had kept in touch through an informal network, therefore, whenever I talked to one of the graduates, I was able to catch up on news about most of the group.

I decided to contact all seven RNs who had continued the process of reaccreditation. I was able to locate six of the seven. The seventh had moved and left no forwarding address. Of the six that I sent letters of information about the study, five replied saying that they were interested in participating. I decided to include all five in the study to explore differences and patterns which might be dependent on different backgrounds. The five represented different age groups, educational background, nursing experience and specialization. Tables 1 and 2 summarize some of this information. The group, at that time, included participants who had completed the process of reaccreditation and were working as RNs as well as participants who were still students of the college program.

The sample, nonetheless, is fairly limited. I did not include RNs from previous ISA programs or RNs who had entered the Refresher program without the experience of the ISA course; neither did I include RNs who had gained accreditation either by studying on their own or by working with a tutor, without the support of a program. However, since ethnography considers that all cultural analysis is intrinsically incomplete, by concentrating on the microscopic, I had to give up the notion of taking care of all possible variables and would have to navigate the tension between completeness and partiality.

Table 1: Summary of Participants' Demographic Characteristics

Participant	Country of Origin	Age	Length of Residence
Helen	Iran	early 40s	two years
Jane	Bosnia	mid 50s	two years
Mary	Korea	early 40s	three years
Nahid	Iran	mid 40s	three years
Violeta	El Salvador	early 30s	ten years (U.S./Canada)

Table 2: Participants' Education and Work Experience

Table 2.1: Education and Work Experience outside Canada

Participant	Education	Work Experience
Helen	BSN, midwifery	-outpatient clinic, prenatal care (13yrs.)
Jane	BSN	-Bosnia (9 yrs.): emergency, OB-Gyne, O.R.-ophthalmology (team leader) -Libya (21 yrs.): O.R. in international and oil company hospitals, polyclinic (head nurse in charge of 10 clinics)
Mary	BSN	-general surgical (3 ½ yrs.), dermatology, central supply (nurse in charge) -R.N. for company -high school health teacher (4 yrs.)
Nahid	BSN, hemodialysis	-hemodialysis unit (4-5 yrs.) -children's hospital, staff nurse, O.R., director of care (17 yrs.)
Violeta	BSN	-community research nurse

Table 2.2: Education and Work Experience in Canada

Participant	ESL Training	Other Training	Work Experience before Reaccreditation	Work Experience after Reaccreditation
Helen	-community ESL	---	---	-part-time intermediate care
Jane	-LINC up to upper advanced	Long term care for NEAs	Nurse's Aide at Women's Hospital	-full-time, temporary in intermediate care
Mary	-Grade 10 and11	---	---	-home support worker
Nahid	-up to college prep	-terminology for health professions	-volunteer in seniors day care centre	-extended and intermediate care (2 locations)
Violeta	-from intermediate to Grade 10	---	-personal care attendant (USA) -volunteer labour companion -long-term care -Nurse's aide in hospital	-extended care -acute care

As I started getting phone calls back from the nurses telling me that they agreed to participate in the study, I felt humbled by the generosity and warmth of their reply. A phrase that I heard repeatedly when I thanked them was "Not at all. For you, anything to help you, Margarita." I felt the weight of responsibility for the trust they were placing in me by giving me their stories for this study.

3.3 Data Collection

The life histories were generated through two interviews with each of the nurses. The length of each interview varied from one hour to two hours. We conducted the first set of interviews in the summer of 1998 and the second set in the early part of 1999. I first explained my interest in looking at the process of reaccreditation of foreign trained RNs when I phoned the participants to check their addresses to mail the recruitment letter. At that time we also got caught up on news about work, family and school for both them and me. When they called back to indicate they were interested in participating, I explained again the purpose of the study and talked in more detail about the interview as a life history. Most felt comfortable with my general request to record their life stories. Mary and Helen wanted more details to prepare for the interview so I faxed them some notes on the type of information in which I was interested (see Appendix 2).

As I prepared myself by reading articles on interviewing and on life histories, I was concerned about the extent to which I should intervene in the flow of the story-telling, how much to interrupt to check for meaning and clarification, how much to let the narrative evolve; to what extent was it going to be a dialogue and to what extent was it to be a relationship of recorder and self-historian. I also worried about the power dynamics between us: how was my former relationship to them as project manager of a program in which they had participated going to colour the interview; perhaps they would not be as candid speaking to me about their experience in the program; they might not feel as free in presenting it in a critical light. However, in general, students in the program had been quite outspoken and assertive. In conversations with some of them during and after the program, they expressed their opinions openly on how to improve the program. Another interesting factor that I saw as

off-setting the power dynamics of my position as former program administrator was that now I was the student; I needed to learn and I was relatively ignorant in the field of nursing.

When it came time for the first set of interviews, I gave the participants options as to where to conduct the interviews: their home, mine, or a coffee shop. I wanted to make it as convenient and comfortable for them as possible. For the first round of interviews, I went to Violeta's and Mary's house while the other three nurses came to mine. The second set of interviews were harder to schedule, Mary, Judy and Helen had completed reaccreditation and were working. Nurses have been in high demand and finding a time among the on-call shifts was not always easy. Violeta managed to make last minute arrangements to come to my house; so did Helen. I visited Mary and Jane in their house while Nahid managed to find some time for a telephone interview. Our encounters usually included a good dose of socializing before and after the interviews. The nurses were much more hospitable to me in their homes than I was with them in mine. While I managed to offer tea or coffee and some cookies, their show of hospitality included, making specialty coffee, offering me vitamins, going out for an afternoon of lattes, having lunch out, preparing lunch for me and bringing me gifts of cookies and pistachio nuts. I countered with comparatively small offerings: fresh oregano, rosemary and roses from my garden.

The interviews were tape-recorded using an omni-directional pressure zone microphone. Although this may have helped alleviate the artificiality imposed by the presence of a tape recorder between me and the story-teller, for the most part, the sessions included some degree of self-consciousness and a sense of heightened performance. Because the interviews were conducted in our homes, we could not escape distractions from telephone calls, cats, birds and children. The first interview with Violeta, for example, was conducted

around the dining-room table while her one-year old daughter was taking a nap right behind me on the sofa. For the second interview, both of our daughters were sick with the flu, watching TV in the living room, while we recorded next door in the kitchen.

My earlier concern about whether to elicit the data through open-ended discussion and/or directed questions played itself out based on two factors: the narrative style of the teller and the stages of the life history. Minister (1991) refers to differences between the narrative styles of men and women, stating that men are more comfortable in taking the floor, using a monologue style, keeping within the limits of selected topics while women are not as accustomed to public performance and feel more comfortable with questions, comments and encouraging remarks, "these interruptions are welcomed ... for they seem to be motivated as much to support speakers as to clarify topics." (p. 33)

While the frame for the life stories in this study fit within the open-ended dialogue format of women's life stories as described above, there were also individual variations. After I opened our sessions with a statement similar to: "Perhaps your could think of your life as a book, and today you are going to tell me about one chapter, the one about being a nurse", the nurses began by telling me about when they first thought of becoming nurses, some continued uninterrupted for long stretches of time, others did not. Violeta and Jane's stories were the longest. They seemed to be very comfortable and enjoy the act of story-telling. Jane's narrative was a casual back-and-forth conversational account. Violeta's segments were longer. She conveyed a sense of having lived a "storied life"; she would, from time to time, foreshadow events in her story by saying that a particular event she was recounting would make sense in light of what would happen to her later on in her life.

Mary spoke for long stretches at a time without interruption. She chose her words very carefully. My sense was that she wanted to be correct and precise in her use of language and in her story. She would check with me from time to time to see if that was the direction to her story or the answer I wanted to hear. She also frequently compared aspects of the nursing system in her country to ones in Canada, making value judgments as to which one was better, sometimes one, sometimes the other.

Nahid tended to stick to facts and events; her interviews were the shortest ones. Helen was also succinct. The segments on her story where short; she waited for me to ask questions. She told me that she had not thought about some of the questions I asked her and could not think of an answer on the spot. If she thought of something else, she would call me. She also felt that she did not have very much to say, that she would have preferred being part of a focus group discussion where comments from others could spark ideas for her.

The stage in the narrative also determined how open or directed the interview process became. In the first interview, most nurses told me their story up to the point of enrolling in the college Refresher program. As we entered the part in their story that was related to reaccreditation, more questions came up for me, perhaps because I was specifically interested in that portion of their lives as nurses. Also, in the second interview, after transcribing and reviewing the first part of the narrative, I had specific questions on points that I wanted expanded or clarified.

3.4 Data Analysis

The data for this study was analyzed for the writing of the narratives and to uncover emergent themes. After the interview sessions, I transcribed the tapes verbatim. I included

field notes on the context and setting of the interviews and, sent a copy of the transcripts to the nurses for their record asking them to let me know if they wanted to omit or add anything. There were no changes requested. Most nurses marveled at the amount of work involved in the transcription and commented on the fact that by reading the print form of their interviews they could see many mistakes in their use of oral English. I reassured them that they had expressed themselves very well in English and that I would edit out any errors in the final narrative. I also promised to send them a copy of it for their review.

Even though I followed the interview transcripts very closely in preparing the narratives, I am ultimately responsible for authoring them. As Reinharz (1992) points out, the researcher does not need to be silenced. My voice, along with the voices of the nurses, is present not only in the interpretation and analysis but through the questions I asked and what I chose to include in the edited versions of the life stories.

In preparing the stories, I edited out my questions, pauses, false starts, phrase fill-ins and repetitions. The editing also included cutting sections or portions of sections, some anecdotes or comments that I felt were not crucial or relevant to the study. Jane's transcript, for example, was reduced from 92 pages to 16. In general, the resulting story followed the same order as the original interview. In a few instances I moved parts around to follow a chronological or thematic order. To keep the flow of the narrative in places I had cut and pasted, I had to include one or two words as an introduction to a sentence or as a connector.

As I promised the nurses, I did edit the stories for syntax, although, in general the level of accuracy in the structure of their language was high. I believe the distinct voices and narrative styles of the nurses survived the editing process. I also changed names of programs and organizations to continue the process of building anonymity begun when the nurses

chose pseudonyms for themselves. After completing the stories, I mailed each one to the corresponding narrator. I wanted to ensure the nurses felt comfortable with the way I was presenting the information they had disclosed in their life stories. I also wanted to check with them that the authenticity of the interviews had come through in the edited stories.

The process of emergent theme analysis also had collaborative elements. It began with the first transcription of the tapes. As I transcribed, as well as recording follow-up questions for the second round of interviews, I jotted down some common themes and categories that were emerging from the data. On the second recording session, I shared with the nurses the issues I saw emerging from the data and asked for their comments; they corroborated my observations and added their own. The process of identifying categories, themes and patterns continued with the editing of the narratives, reading and re-reading the data. I used different colours of highlight pens for different themes, underlined the text, annotated the margins, created charts and outlines always referring back to the data and relating it to issues arising from the literature review.

3.5 Limitations

In this section I want to address some issues relating to goodness or quality criteria as well as some ethical considerations. I will examine the soundness of this qualitative study against a constructivist framework (Lincoln & Guba, 1985) using criteria of credibility, transferability, confirmability and dependability. After considering the trustworthiness of the study, I will revert to a critical perspective (Lather, 1991) for issues of authenticity (Guba & Lincoln, 1994).

Credibility refers to the extent to which the participants and the topic in the study are accurately described. The credibility of this study was enhanced by developing a collaborative relationship with the participants allowing me to provide as full a description as possible. The richness and fullness of the description was also enhanced by the use of five life histories rather than one. Throughout the study I have also been aware of biases and assumptions by being reflexive of my perspective on the subject and on my triple role as former project manager, ESL instructor and researcher. A final point contributing to the credibility of the study is the fact that I checked the data with participants by having them review the transcripts of the interviews and the edited life stories, as well as discussing with them some of the emergent themes.

Transferability refers to the extent to which the findings of a study may be transferred to other cases. Unlike quantitative research where inferences regarding a population are made based on the data collected from a representative sample, it would be misguided to apply measures of quantitative generalization to this study since the cases selected are not representative of the total population of foreign educated nurses who attained reaccreditation. A limitation to this study is the fact that while triangulating multiple sources of data is a strategy that enhances transferability, given the model I chose for this study, life story, there was only one source of data: the interviews with the nurses. Further sources of data may have included classroom observations, interviews with instructors, doctors and co-workers. Although the method of research in this study does not allow for generalization to other nurse or professional populations or to other educational or work settings, the richness, detail of the data and analysis allows for an increased range of interpretations of the process of

reaccreditation for nurses educated abroad. As well, the depth, richness and detail in this study may be useful to future studies in making comparisons with the present study.

Confirmability of qualitative research is attained not by being detached as in quantitative studies which are guided by the search of objectivity but rather increases in value through prolonged contact with the data. The natural subjectivity of qualitative research is more likely to enhance insights into the complexity of the social phenomenon. The confirmability of this study was enhanced through the verbatim transcription of the interviews, notes and memos kept during transcription, the careful editing of transcripts into life stories, reading and re-reading of data, highlighting, underlining and annotating the stories, keeping charts and outlines establishing categories of emergent themes, going back to the data and refining the categories. As well as examining the data for possible rival hypotheses, as this study is a masters' thesis I had recourse to what Marshall and Rossman (1995) call a "devil's advocate" (p. 145) in the form of my advisor and committee to question my analyses.

In the construct of dependability, the researcher attempts to account for changing conditions in the phenomenon and in the design as the study progresses over time. Dependability was attained by paying diligent attention and making explicit the many sources of variation in the design of the study (researcher role, participant selection, social context, data analysis strategies) and in the data collection (enhanced through verbatim accounts, low-inference descriptors, mechanically recorded data and participant review).

Finally, I would like the study to be evaluated by its catalytic validity (Lather, 1991), to what extent has the research process been a catalyst towards knowing reality in order to transform it? Will the study have an impact in shaping programs and policies that will

contribute to more equitable working opportunities and conditions for immigrant professionals? Has the study had an impact on the five nurses by providing an opportunity to reflect on the process of reaccreditation and gaining some validation for the complexities and difficulties inherent in this process? These are questions I can not answer at this time or from my perspective. I do know, however, that the study has had an impact on me as an ESL instructor. It has broadened and deepened my understanding of what my students' perceptions regarding language, culture and identity might be and how these perceptions may impact on pedagogical issues.

To conclude this section I will comment on ethical issues. As well as taking care of extrinsic mechanisms such as completing forms for informed consent, the ethical considerations for me as researcher included intrinsic considerations. Through the interviews, the nurses disclosed information of a personal nature. They expressed views on specific programs and instructors with whom they had been involved in the past as well as with current co-workers, patients and doctors. We took care to insure confidentiality by changing some of the facts, using pseudonyms for people and places. The difficult question of unequal relationships of power between researcher and researched lending itself to exploitation, I resolved for myself by viewing the five women as professionals, expert in their field. I took care in trying to make transparent my interest in the study and my assumptions. Sending transcripts of interviews, copies of the life stories and sharing with them some of the themes I saw emerging from the data, were also prompted by my concern over establishing an equitable, ethical relationship with the five nurses.

3.6 Research Questions

I am restating the research questions at the end of this chapter so the reader may keep them in mind as a framework when reading the following chapter which consists of the life stories of the five nurses. The purpose of this study is to explore how foreign educated nurses experience the process of seeking to work again in their profession, once they immigrate to Canada, more specifically:

1. How do foreign educated nurses perceive the nature of nursing in which they were socialized in their own country and in Canada? That is, what are the social, cultural, linguistic, and professional norms and values of the occupation as perceived by nurses seeking re-accreditation?

2. How do foreign educated nurses become socialized into the culture of Canadian nursing through the reaccreditation process and programs designed to assist them?

3. What are foreign educated nurses' perceptions of language socialization after reaccreditation? In other words, how do they predict they will continue to be socialized into the profession of nursing in Canada?

Chapter Four

Five Life Histories

This chapter presents the life stories of five nurses educated abroad, who sought reaccreditation in order to work in their profession in Canada. I hope that re-telling their stories will serve as a source of inspiration and information to other foreign educated nurses embarking in a similar venture.

To assist the reader in placing the narrator I will include at the beginning of each story a point-form sketch of biographical data for the nurse up to the time she emigrated to Canada.

-from Iran -in her early 40s

-as a child, wanted to be a doctor -nursing, second choice -BSN, specialization in midwifery

-only nurse in outpatient clinic, pre-natal care (13 yrs.)

Helen

I was always interested in being a nurse, in wearing a white gown. When I was a child playing with my dolls, I pretended I was taking care of my patients. In my family nobody was a nurse or a doctor; I just got this idea when my mother got sick. I was thirteen years old; she had a brain tumor, so I visited her in the hospital and after she came back home I realized that the doctors and nurses helped my mom get well. Maybe after that I became

interested in this area.

When I finished high school I could choose from ten subjects; nursing was my second choice. The first one was medicine but I didn't get it because of my score or because so many people apply for medicine. Finally, I was accepted into nursing; I was happy that I could have my dream come true. I moved to the city where the nursing program was offered and I studied nursing for three years plus summers. Actually, it was four years but compressed.

After I finished nursing school, I worked for the government because we had a contract with the university to work for two years for our free education. I worked in a women's hospital. I liked the work. I love people and I love to help anybody that needs me. In nursing I found that I can help people when they are sick, the time when they need more help. I love to take care of patients who have pain and give them something verbally or an analgesic, something so that the pain gets relieved; then I feel satisfied. During my two years working in the women's hospital I became interested in midwifery. So, I took a two-year midwifery course. Many people applied for this midwifery course because they could work independently, but the number that they took was limited. I was so happy that I got accepted to the course. We were seventeen and as I remember, my score was close to the highest. If I accept something, I put my whole energy into it.

After I finished, I applied for a job in that field. I got a position in a private clinic where I worked for almost thirteen years. Thirteen years in that clinic! It was like a walk-in clinic, offering prenatal care. I decided not to accept work in delivery because at that time I had children; I had two, so I couldn't because the pregnant women needed me maybe during the night. After nine months I gave them their hospital referral; they went to the hospital and

delivered the baby. By that time everything was OK. I checked everything; blood pressure, weight, and everything was OK; so they didn't have any problem.

In the clinic there were many nurses but in prenatal care just me. I enjoyed working there. If I had any questions I could go and ask because there was always a doctor I could count on. The relationship between doctors and nurses in Iran depends on the area where you work. Sometimes they're friendly, they work together, but sometimes they're like a boss and an employee. In my area, because it was a small area, not a big hospital, we were friendly.

I was there 13 years, and then I quit my job two years before I came to Canada, because I wanted to learn the language, English, and get everything ready. I studied on and off for two years, but back home we didn't have the opportunity to talk. We learned, whatever we learned in class and we left and went home. There was nobody there to practice. To learn a language you need to, you have to talk. You should feel this need that you have to talk, but whenever you can continue with your language you go back to it.

Sometimes, sometimes I miss my position, and my job, and my workplace but I'm happy here because it's good for the whole family, actually for my children to get a better education, in a stable environment, politically and in every way! I moved mostly because of my children. Otherwise I didn't have any problems there; I was happy. Still, I'm also happy to be here. Nothing has changed in my mind.

When I moved here, I went to the RNA to ask what they needed from me to be a nurse here. I had heard that they had positions for nurses in Canada; that foreign nurses could continue their career here after they got a license; and that it took time. I knew everything before I came. I knew that there was an association where you should submit your documents

to be evaluated and if everything was OK, you just needed to prove that you knew the language in some way. When they told me "You need TOEFL," I didn't have any idea about TOEFL and TSE. They told me "Because you weren't out of work for more than five years, you just need to have the TOEFL and TSE and then you can register for the exam." At first, I thought it was easy to have TOEFL and TSE but when I wrote the first TOEFL I thought, "No, I can't get this score." But I heard from one of my friends about the ISA program. It was a hope for me that this program was for nurses and they prepared nurses to write TOEFL and be familiar with nursing in Canada. So it was a hope.

At the time, I was taking English classes off and on, not continuously. They were school board classes. When I went to these classes, I realized that the people there did not have an academic background; they were mostly housekeepers. So, when my teacher realized that I was a nurse back home, that I had this education, she told me, "You can go to Queen Victoria College (QVC). They have higher levels, advanced English." Around that time I heard about ISA, so I decided to go to ISA instead of QVC. Actually, I applied at QVC but it had a long waiting list, about eight months. So during that time I heard about ISA, I applied and I got in.

It was good to have other nurses in class to talk about our background. As well, we all wanted one thing, to be a nurse in Canada. That was a good part of this program; we encouraged each other to reach our goal. Whoever had any information, would come and share it, how to move faster this way or that way. In ISA I heard about the refresher program for nurses.

Because it was a full time program, we had the opportunity to talk English, otherwise

for **me**, I didn't speak any English in my house. That part was OK for me, to have other people so I was forced to talk English.

I also got a general idea of what nursing was like in Canada. We visited two or three places, hospitals, as a tour, and also we read one book about how nurses act in the hospital.

The program also helped me with the TOEFL but not as much as I had expected. I expected I would pass before finishing this program but just a few people did. I got 517 at ISA and then I wrote it twice more. The TSE score didn't improve since I was in ISA. I got 40 and then when I was in the college I got 40 **again**. But I know that my English has improved; maybe it's the anxiety during the exam.

I decided to continue at the college when I finished at ISA. I didn't really have to because it's a refresher program, but I thought it was better to have this program to be more confident to work as a nurse in Canada, otherwise you don't have any idea what nurses do. In general, I think nursing is the same. Basic nursing is taking care of the patient, being a caring person, but the language is different. That's part of the problem, learning a new language, using that language in the job. Before starting the refresher, I thought that maybe this, communication, was the difference, the difference between our nursing back home and here. Communication and knowing the culture of the patient. Because the culture is different, so the communication should be different. And it is quite different from back home. Here you just give information to the patient and it's the patient who decides what she wants to do or he wants to do. Back home nurses are like a boss because they know more than the patient, so they decide what is good for him, but here you have to check with the patient, what **they** want you to do for them. For example, if the patient decides not to have a blood transfusion,

you can't force the patient to have one. You know that this transfusion is good for this patient. You can save his life or a life, but if he decides not to have it, you should respect the patient's decision. This is a challenge for us, inside us, because we know what's good, but we have to respect the patient's decision. Back home the patient needs to give consent only for surgery, but otherwise, in taking care of patients you did whatever you decided was good for them. I think with adults who are mentally competent it's better if they decide, because it's their life.

The communication that we learned during this refresher program, I think helped me to communicate with the patient more efficiently. We should have therapeutic communication with the patient; just let the patient know that we understand what she said, kind of repeating the words that she says to us and encourage the patient to talk more about his feelings. We practiced at first with our colleagues, our classmates, and then in my practicum. At first it was difficult, just repeating words that the patient says to us, and encourage, at the same time encourage the patient to talk about his feelings instead of giving advice to the patient. When the patient has problems she wants to talk to us but she doesn't want our advice. Back home we just thought that the patient wanted our advice, so we went ahead and gave advice. Here, we are not supposed to give advice to a patient; we just inform the patient; it's the patient who decides. I'm getting used to this kind of communication. At first it was a little strange for us. We can use this in our communication with other people as well and it helps. I try to use it at home with my son and my children. Sometimes, I realize that it's useful to get them to talk more about their feelings.

Another cultural difference is to be assertive here. In our culture, we mix it with being

aggressive, but here, if you are assertive, it doesn't mean that you are aggressive. It means that if you are not comfortable with something, you go ahead and let your colleague know about your feelings and you say, "This is **me** that feels uncomfortable" or "**I** don't feel comfortable with the way you did this", not "**You** make me uncomfortable." Don't put the pressure on your colleague. So that was the other new part of communication between nurse and colleagues. We can use this type of communication with patients as well, for example, one day a patient was throwing things, she was angry about something. So, I saw one of the nurses go ahead and tell the patient, "I know you're upset about your diagnosis and you think you don't have any control over your hospitalization, and you feel angry about that. That's OK. You feel angry, but the way you throw things is not an OK way to show your anger." So, I realized that the patient calmed down; the nurse understood the feeling the patient had; she was frustrated or angry about her diagnosis. I know the way I should, the way I want to communicate but I think I need more practice. But I do know the way that they communicate here with the patient. I think, the refresher program is really excellent, otherwise, I think we would never learn if we didn't have this training. The feedback that the college gets every year about the foreign educated nurses that already work in the hospitals is that they are not assertive enough. Maybe because of their background, their culture, because we were trained to follow doctor's directions but here you can question the doctor's orders. We are allowed to question if we see that the doctor's orders are not appropriate for the patient's age or weight. We can call the doctor or talk to the doctor and question the order, but back home we never did that. Here, it is part of our training; we have the knowledge about the medication and if see something that is wrong, we can, we are allowed to. Back home, no. It's a cultural thing.

It's something that maybe nurses need time to change their personality. I'll try to be more assertive.

Almost 70% of the questions in the RN exam are on communication or psycho-social questions, and about 30% or maybe less, on physio-pathology or signs and symptoms of disease. To be a nurse you have to write this exam and if you don't know how to answer these psycho-social questions the way that they want or the way the culture is, you will never pass this exam. Without any training, just by living here, I don't think that we learn. No, we have to have this training.

It's not only hard for us. When I was working in the Broadway Hospital, I talked to one of the nurses about these psycho-social questions and she told me, "It's hard for us as well." We get four choices. Two are quite wrong, we know already as soon as we read them, but the other two are so close. But I think, in general, nurses here would be OK. They know the culture and the way they should communicate with the patient or with the colleague but for us as foreign nurses, it's quite different; we have to learn here. For example, when I was writing this exam in the college there were so many questions about "If you are working in a nursing home and you have two male patients and they want to be together, what should you do?" So, I was thinking if I were back home we never let these patients be together in the hospital or in a nursing home but here they are allowed to be together; this is their right. You should just give them privacy. But if I didn't take this program, I would never know that this is their right, to be together in the hospital area.

In the refresher, we had theory about anatomy, physiology, and disease, pediatrics, obstetrics. We had everything in theory and then we had practicums in medical and surgical

units. In general the workload was too heavy because it was nine months and you had to study **everything**. The workload was a little bit heavy at the beginning; we had to put more time to study at home but, afterward it became a little bit easier.

We also had a course in Sociology about Canada in general, about First Nations and the different cultures that we have in Canada, different languages, and how they treat different people, like visible minorities. These people that came from other countries, like Asia, in general they say that they are equal but deep down, they are not on an equal basis with Canadians; it means that you shouldn't expect to get a job if a Canadian applies for that job at the same time you apply for the job; the Canadian always gets the job, you know?

In Anatomy and Physiology we were just reviewing our knowledge in a different language. I didn't find it difficult because back home we studied in Latin so we pronounced the words the same way.

In the refresher program all we learn is in theory so in the practicum we experience what it's like and we apply that theory. It's a reassurance, that you are doing well and that this is still the kind of work you are looking for. We need that, to know that we are still OK. The practicum made us feel more confident. It was very helpful to get this confidence, to know that we could. For the last three weeks we just worked independently and gave medication and communicated with the patient and everything was fine. I felt more confident about what I could do. Still, language is a difficult part, but with the patient, we don't need that much language. This much that I have is OK to communicate with the patient, understand the patient, and give her answers. I know that I need more language. But with this much that I have I don't have any problem to communicate with colleagues or patients.

Still, there is a place to improve, room for improvement! I think I will get that on the job. I have the opportunity to talk more. We had to write reports but I didn't have any problem in writing. This confidence that I have now, I didn't have at the beginning. I didn't have this confidence that I can go ahead and apply for a job because I didn't have any idea of the health care system, of hospitals here and how nurses work, but now I know. I know that I still want to be a nurse and work as a nurse, no changes in that feeling. I'm happy that we have this opportunity, because for other professions it's not there, this opportunity to have documents evaluated and to take a course for nurses. This is a privilege.

We had English but just maybe, just to prepare us to write TOEFL. They put too much pressure on TSE. I think it's not fair that in 20 minutes they decide that this nurse can work or not, because outside it's different; you can explain more. I think a certain amount of language is important to have but not that much. The TSE is something you have to be fast at because you get the question and you have to think fast about that question and answer. That is something that maybe in our language is also difficult, to get something that is new and you have a limited time to think about. If English is a second language for you, it makes it harder. I think TSE is not a good test because when I was doing my practicum, my instructor told me, "Your patient understands you, and you can communicate. I wonder why you didn't get a score of at least 45 or 50, because in the hospital you can communicate with your colleagues, they understand you." Maybe it's the stress level during this test.

I think when we come here, we can go ahead and write the exam and get a job. For **me,** I felt more comfortable taking the refresher program because just writing the exam and passing the exam and starting to work is not enough. The communication that we learned

during the refresher program and the practicum gave us more confidence, and we learned the way that they want us to work. I think the refresher program should be for all nurses from abroad. It would help a lot. The refresher is a very intense course. In the beginning it seems that we can never make it but in the end we are proud of ourselves that we did it. It was a lot; it was tense, an intense course, but we made the refresher course number one in our lives, then the other things came in second place and third place but in the end we enjoyed it. Yeah, I did it!

After the refresher, I wrote the exam; I passed and I went to the RNA to be registered as an RN. After that, I put my resume in two or three places to find a job, and I had interviews in two places. I got hired in one and then after two weeks the other place also called me. They wanted me to start but I preferred to be just in one place to start because there were lots of new things that I had to catch up on. The place where I work is an intermediate care lodge with one hundred residents. On each shift there are two nurses. Each nurse has fifty residents to take care of medication and other work. So, I prefer to be in one place and learn, but there's always opportunities to work in two, three places. They ask for nurses a lot. There's a shortage of nurses everywhere. My friends that finished with me are working in so many places. More than full time jobs. I prefer just to work part time because I want to be with my family; my husband is not here. So part time work is OK for me, for now. Sometimes I get three shifts a week; three eight hour shifts, sometimes less than that, sometimes more but in all, I get part time hours, half of full time. I've been working there for almost three and a half months now.

In the future, I'm interested in taking a Geriatrics course. To take this course at the

college we have to have one year's experience working in a nursing home. I'd like to learn more about Geriatrics to give me more opportunities. You become a specialist, and they are looking for whoever has more experience and more knowledge in this area. If I take this geriatrics course, I can work in extended care as well.

In the nursing home, the nurse has to communicate with the elderly. They like to talk; they love talking and sharing their experience with nurses. I am amazed at how they accept us. We are accepted coming from a different country, with a different language; they understand us. If you have an accent, they understand and they don't tell you "Oh, I don't understand your accent;" they say "You got a nice accent. What country are you from?" They are so kind. As patients, elderly people are different. They enjoy talking, sharing their experience. When you are a midwife you work with people at the beginning of life; They just want to give birth but now it's at the end of their life. Maybe it's because of my age. I'm getting older so I prefer to work with elderly, or I miss my parents; this is a way I can feel that I am close by them.

I just started; it's not been a long time just three months and a half and I've worked off and on part time, but I think, while working, I'm still learning. With this much English that I have, I can communicate with co-workers, doctors and do the forms. If I need to talk to a doctor about a resident's situation, I don't have any problem; I dial and tell them. If I want to chart, sometimes I have a spelling problem; I ask my co-worker, "Is this right to spell it like this?" I can resolve it by asking; it can't prevent me from doing my job. Sometimes I have problems reading doctor's writing; everybody has trouble reading doctor's writing! but I don't hesitate to ask if I see the doctor or I ask my co-workers, "What is that?" because I want to be

familiar with the handwriting. A certain amount of language is necessary to start but after that you work everyday and you learn everyday, by working, by communicating with others. We have to use the workplace. That's the way you learn the language, you make mistakes and then you correct your mistake or you listen to the others talk. It comes!

Have I changed as a nurse? I can't say that I've changed as a nurse but my area of work has changed. I worked as a midwife and as a nurse both in a private clinic, but now I work in a residential area, with fifty residents. So, the area has changed but have I changed? I haven't thought about it.

I think nurses from other countries can do the job here, work as nurses here but the difference is between these two cultures; the differences is language, culture, but as a nurse it's the same working as a nurse with patients. I don't have any difference here, just language.

-from Bosnia -in her mid 50s

-studied nursing against parents' wishes -BSN

Bosnia (9 yrs.): emergency, OB-Gine, O.R.-ophthalmology (team leader)

Libya (21 yrs.): O.R. in international and oil company hospitals, polyclinic (head nurse in charge of 10 clinics)

-Returned to Bosnia twice for sons' education; could not find employment → war.

Jane

Mine is a long story. I have been working as a nurse for around thirty years. I like to help people and when I'm caring for patients from my heart, I'm happy. Even though my parents wanted something else, I decided to go for nursing. I studied in Bosnia for four years. We were not allowed to do many things as student nurses. The practicum there is quite different from the one I just finished with the refresher course. Here, we get really good experience; it prepares us to be confident, familiar with the RN's responsibilities, systems, care of patients, the way to approach patients. During school, when you are young, you are not aware of the importance of the practicum and of learning as much as possible from it. It's fun, and we want to get good grades. We're not aware that it's real **life**, it's not just **grades**. They're real patients! It's an opportunity to share the experience of older colleagues.

When I graduated in 1964, my first professional experience was working in emergency. Work was OK; it was stressful, but I didn't consider changing my profession. From emergency, I worked two years in OB-Gyne and then in O.R. for ophthalmology. I worked there for a few years as a team leader, responsible for scheduling and administering medications for all patients. Every day I had to register what they were taking. I couldn't

manage during my work day. I took all the books home to finish the paperwork. It was hard but you knew your doctor respected you and trusted that you could do the work. I was getting a better position and respect. Later, as a head nurse I reached the top of our hierarchy. That's a **lot** of responsibility. I had ten clinics under my umbrella. Ten clinics to organize all schedules for nurses, doctors, pharmacists and maintenance. It was really hard but I managed and my director was happy with me. I see myself as a responsible person; I try to do my best, always trying, always eager to learn. The point is if everything is covered, if you work as a team, it benefits the team and benefits the patients. At least once a month, I used to have a kind of in-service meeting to talk out problems, to see what we could do to improve.

Between 1964 and 1973 I worked in Bosnia. In 1973 I went to Libya. There, I worked in OR. There were all type of operations in that OR, from surgical to orthopedic, to ENT, to ophthalmology. I learned a lot. Until then, I had only been trained for eye surgery. It was tough because of the language barrier. Arabic is a hard language to learn. I didn't know anything; I didn't know anything about the surgical area. That was a **really tough time**. It was really hard. So many times I would be crying! working and crying at the same time. I communicated at the beginning with my hands, legs, head, with whatever! Gestures! That was really fun. This was an international hospital with people from everywhere, India, Egypt, Palestine, Pakistan, Bulgaria, Greece, the Sudan. We learned the hard way. I never learned how to write, just how to speak Arabic. I could manage although it wasn't correct, just what I picked up in the hospital, the street, in shops. English was also used, for instruments, for example. The English that I started there I think is **really** wrong. I borrowed books from friends and I had a few books of my own and tapes. It was just awful. I never learned correct English. There were no schools, there were no official courses. You were on your own. But

people are really kind; what was important was that we understood each other. After a few months I was on my own. I worked in OR from 73 to 80. I like the OR area; it is easier to reach your goal than in medical: there is the knife; there is the operation; and you can see improvement in patients right away.

After 1980 the hospital closed so I went to another hospital just for oil company employees and their families. In Libya I saw myself as a Bosnian-Libyan nurse, always aware of cultural differences. I was a nurse, I am a nurse and I think that it will always be the same story. I also worked in Switzerland and I was aware of Western European culture, but in Libya, cultural differences were quite big. Females don't have rights, the members of the male population are the bosses there. I had a cesarean section and my husband signed for me. I had to laugh. I said, "Sorry doctor, who is going for the operation? Me or my husband?" That's the law; the husband will sign for everything. You have to be aware of how to approach and how to treat people. First of all, if we start from the waiting room, when you enter the hospital, there are two waiting rooms, one is for females, the other for males. You should just be aware of these differences, you should observe and ask, ask. If you behave professionally, you won't have any problems. If you are responsible, if you are kind, if you are a caring person as a nurse, you won't have any problems. There are some misunderstandings, of course. But nursing is everywhere nursing.

I was with my family in Libya. My husband was working there too and my children were born there. We knew people, we knew the hospitals, it was easy. But it is not a country where we could educate our children the way we wanted. Libyan universities are not recognized internationally and everything is in Arabic. We applied for Canada; we got the papers and we were called for the first interview but my husband said, "No, it's fa-a-a-ar

away and I'm not ready to go." So, in 1986 I went to Bosnia for two years, tried to get a job, but couldn't. We went back to Libya and I got a position as head nurse in a hospital that was only for outpatients, like a polyclinic made up of ten clinics, with ultrasound, endoscopy, dressing treatment, injection room, but not surgery or emergency. Everything was going smoothly, but I didn't have my hands on patients. It was just paperwork and organization, it's not nursing. My husband decided to stay for a few more years, I resigned and went to Bosnia for my children's school. The war erupted ... I escaped with my children and went back to Libya again. The director of the last hospital where I had worked offered me a position as supervisor of the afternoon shift. It was easy going. I knew everything, but again, I didn't have my hands on patients. You are out, if you're not up to date, you're out. Many things change, new equipment, electronics. Being with patients is a great responsibility; you must have confidence and keep up to date.

We decided to come to Canada for the future of my children. I wanted them to have a good education and a good country to settle in, to have a bright future and not to be afraid. When we came here, I was ready to work at anything, just to support my family. I knew that to get everything verified and pass all stages for nursing was hard. I knew that it was hard, but I didn't know exactly how hard it would be.

When we came, I heard about a course for long term care aides, at the same time, I applied with the RNA for reaccreditation. I said to myself, "Let me see what I can do." I asked the nurse there how long it would take and she said "Three years." I said to myself, "No way!" She was right.

Language was the biggest barrier, the biggest barrier, even now. When I came, I thought I knew some English. It was really nothing, maybe some vocabulary, broken

English. I went to the LINC program for four months; I took two more courses at the QVC campus, then the Long Term Care Program. It was a challenge program for foreign educated nurses with courses in Dementia and Alzheimer, a practicum and an exam.

Long term care is not nursing, it is just care of patients. It's not really the nursing for which we were trained. If you are a foreign nurse and you need the money and you need to work on language, you don't have a choice. But if you're working, there's no way that you can improve your language. Language can be improved only if you study, study at school. At one point I was working as a care aide and taking a TOEFL preparation course. **No way!** I was going evenings after a twelve hour shift. **I didn't know what they were talking about!** I was so tired and on top of that you have your family, you have responsibilities at home. So, if foreign educated nurses have the opportunity to study English first of all, **English**, good English, this is the best way. They can accomplish everything better, with less stress. The requirements for a foreign educated nurse are just too high without knowing English. You can't function out there in the field if your English is not good. There are so many legal issues; you have to chart everything you are doing for each patient; you should read the doctors' orders, take doctors' orders over the phone; you should interact with patients, document everything, follow instruction manuals. If your English is not at college level, too bad; it's too hard; it's no good. I mean, it's impossible. As a care aide you can because you are not giving treatments; you are not giving meds; you are not charting; you are not doing anything as a nurse, nothing ... nothing, just care. That's it.

I did learn about Dementia and Alzheimer, which are really big issues now, especially because the baby-boomers are entering this age. Nursing homes are everywhere and there will be a big demand for RNs. I think by the year 2003 there will be a 50% shortage of RNs.

During my practicum I kept my eyes on the nurses. **Always!** I will tell you a funny story: between the ISA program and the refresher, I got a job as a care aide at Women's Hospital delivery and OR, and all the time during OR, I would just look in. The leader nurse knew that I'm an RN; she said, "You are **dying** to go inside!" I said, "**Yes**, that's true." You can't change. I mean, I can't change.

Even though I tried to see what nurses did, the care aide practicum didn't help me get a sense of what nurses do here, because I didn't interact with them. I was on the same team but I didn't know what they were doing. They were doing their job and nurse's aides were doing theirs. Everybody is busy. Still, it was a really good experience because there I found out it was not something that I wanted to do in my future. I decided to go for the license. I said, "Just to waste 30 years of my experience ... No! No!"

When I finished the Long Term Care Aide course, I looked for work. I applied everywhere! and I couldn't get a job, even with the course and my 30 years of experience. Nothing happened, it was really frustrating ... after 30 years of experience...

Then I heard about the ISA course for Foreign Educated Nurses. That course helped me organize myself. There, we learned about the refresher program and about all the procedure we should follow. The program manager encouraged us to apply, gave us information about the program, even brought application forms and checked them after we filled them out. I was determined to get the license as a registered nurse. We learned a lot from each other. The speakers we had were useful; they presented different fields of nursing, like community nursing, information about legal issues, confidentiality; that was useful.

The stress in that program should have been more on language, on English that we need in general. TOEFL is based on general knowledge and if you are not ready with

grammar and listening and reading comprehension, you can't pass it. Our English teacher was such a nice lady! But I think we needed somebody more forceful. Foreign educated nurses are used to a system where the teacher is authority. We need more structure, exams, marks. We are used to a different system. Here it's up to you, if you want to study, you study, if you don't want to , it's up to you, you won't pass. We were not aware of that yet when we started here. We needed someone to guide us.

The nursing we had during the program, we didn't understand a word of it! It's good to introduce us to North American culture and nursing. Psycho-social aspects are really important, they're different than in Europe, for example. However, if the language barrier is there, you don't understand. We were not even familiar with words like "nursing process." We need academic standards, exams to pass from the TOEFL prep to the nursing part of the program. We should go from LINC all the way up to Grade 12 level. When you are finished the college preparatory courses you are ready. Then go into the refresher if it's required.

After ISA I went back to QVC; I took upper advanced, reading comprehension, college preparatory. After that, I got a job at Women's Hospital as a care aide and I got accepted for the refresher. I was in a dilemma; I needed the money; my husband was a student, taking a course in pharmacy even though he is a pharmacist; and my two sons were also students. I couldn't, I couldn't go to the refresher. But maybe it was better that way because I worked for a year, and then got UI when I had my refresher. At least my rent was paid.

The course was hard, and the biggest problem, again during the course was TOEFL and TSE. At ISA I had got 510; a year later, before going into college, I got 537. I was stuck there for a while. After a year at college I jumped to a score of 560. I had been reading a lot

for my courses; that's what made the difference. I'm planning now to keep on reading; I started already, and I'm going back to grammar. I'm aware of my grammar mistakes and I don't want that stuff.

TSE, I didn't get the score I needed. I applied for a waver and I was lucky to get it. You don't have time for English at the refresher. You ... don't ... have ... time other than for nursing. So many pages you have to read; there's so many pages. You can't; physically, you can't. Everyday I was at school from nine to four; I got home at around five, had dinner together, one hour to rest; at eight I went to my room to study and by 12 I was already tired. The next day I would get up at least one or two hours earlier to read more nursing, nursing, nursing, nursing, nursing. My TOEFL score jumped, but my spoken English was left behind. I didn't improve because I didn't study. Most of us were the same; we didn't have time. We had to take the course but the instructor was such a nice lady, just like at the ISA course. Too soft, too soft. We had a kind of a review of grammar. The instructor would say, "Read from page five to fifteen" and that was it. We would have some homework and we would copy it from each other because we didn't have time; we were studying nursing for the exam we would have the following day. So that English stuff there was just kind of review.

Communication Skills was new for us, completely new. For example, you should never assure patients; never tell them that everything will be OK. That's the wrong type of communication. We used to say back home, "Don't worry, everything will be OK". We have a different culture, a different way of communication, so the Communication Skills course was really useful.

The rest of the courses in the program were OK; I mean, anatomy is anatomy everywhere. The hardest part of that course was time, time, not enough time. There were so

many pages to read! I had only Friday evenings off. Saturday mornings, I would take my book and study, all Saturday, all day, no friends, nothing, no social life. It's a hard course; you really need to study at least, a minimum of four or five hours **every day**, sometimes more. Everybody at home knew; "Sorry guys, we have to do it this way." My husband was in the kitchen; he cooked and did everything. At the end of the course he was exhausted. He was working and taking care of everything. I heard that the husband of a student from a previous class ended up divorcing her. Without your family's support, you can't do it; you don't have time for anything except for studying.

My goal to be an RN kept me going. I knew why I was doing this, and I knew the refresher was the right way. Even though it is not required I recommend it for every single foreign educated nurse. I don't know how they are functioning out there without it. That program gives you a complete review of nursing and specially it prepares you to work in the North American health system. It's different and I don't know how people make out without it. Nursing here is completely different. Nurses have autonomy while back home the doctor was always behind us. I did what the doctor told me to do and that was it. Here, nurses perform most of the duties independently; the doctor will come only to visit patients, a short visit, write orders and that's it. He's disappeared; everything rests on the nurse's shoulders. Language is part of it. You can't function without good language; you can't document anything if your English is not OK. Everything is a legal document, every single word you write. You learn that language doing the refresher, from the first day until the last day of the practicum (we don't learn it in the ESL class.) The refresher gives you everything that you need to be confident.

When I finished the refresher I took my exam. The first time was in June. I missed a

few questions so I wrote again in October. I received my result that I passed in the middle of November. I applied for work and I thought it would take at least one month to find something. Believe it or not, they started calling me right away. I wasn't ready because I hadn't paid for my license! I had many interviews. One nursing home offered me full time temporary work from December first till June first for a maternity leave. Now I hear that the person I'm replacing is coming back earlier so I started applying again and I am accepted at a hospital for extended care. I would like to work at a hospital; I'm a hospital nurse. Even though this place is nice where I'm working now, I'm used to having clear regulations. A hospital, is a hospital; in intermediate care, on the other hand, there's no unit clerk, there's no staffing office, there's so much paperwork. Everything takes you away from the residents. I want to spend time with them; I want to talk to a resident if I see that he or she is sad, agitated. I'm not thinking about going into acute care any more. I had enough of acute care and I like the elderly. Also, I think with all my experience and knowledge I can really be a good nurse in this area. Of course, I'd like to have a full time position. If you are lucky it should take a few months. Now, I'm looking for something that is at least permanent part time. I plan on having only two places; I don't want to fly from place to place. It all depends on how lucky you are. Our luck is really that nurses are in demand now. There is a shortage of nursing staff. Our instructor for the refresher told us last time we had dinner with her that the average age for nurses right now is 45. I've heard that many nurses are going abroad to the USA, the salary is better and they are offered full time positions right away.

Between the first exam and the second exam I was in Europe. When I came back I tried to get our tutor from the college; she is the best one; she'll tell you right to the point what is right, what is wrong, no doubt. The tutor said to me, "You are really late, I only

accept students for 3 months." I had two months left. So, a friend of mine from that program who had started with that tutor and I decided to study together. The next day after she had the session with the tutor, we would get together to go over the session and the hand outs. That's the way it worked.

The first time I sat for the CNAT was really confusing, not the medical part but the psycho-social. Many things were unclear for me, like the code of ethics. The second time it was easy, after the tutor explained it to us in just a simple sentence: "The code of ethics is moral." For example, who is responsible for the signed consent? The doctor is responsible. We are responsible as a nurse to see that it is signed but the doctor is the one who is responsible. Our moral obligation with clients, is part of our code of ethics. For example, you can't have any relationship with patients; it's against the code of ethics. After one year when the patient is discharged you can have a personal relationship. Also you can't accept anything from patients except for a "Thank you" or flowers that you are going to share with colleagues in the nursing station. So, that stuff wasn't so clear about differences between code of ethics and standards. Standard of nursing is how we provide care.

It is really difficult to learn on your own from books for the exam. Books don't cover therapeutic and non-therapeutic communication, charting, mathematics. Then, when you go for an interview they ask you questions from the CNATs and from real work! For example, they might give you a math question: "The doctor ordered 25mg of any morphine and on hand you have a vile of 50mg. How much do you need to give?" They might also ask you about the five rights and three checks. Three checks means you will check medications before, during and after you take it from the vile. The five rights are: right patient, right dose, right route, right time, right.... This stuff we learned in college during the practicum; we had

the instructor beside us all the time. It looks simple but it's so important. That is the North American standard! and you should know it. Everybody expects you to know. You are a registered nurse so, I'm sorry, after you get a job, the orientation is a few days, only a few days, that's it. I don't know how people manage to work without the refresher. It must be hard, must be really hard.

I'm still in touch with many of the nurses from the refresher. We talk and share information and experiences on interviews, how many, where, what questions; we also talk about work, just to get a sense of what's going on, even though every place is different.

In the orientation you learn about the paperwork and medications ... so many medications at the nursing home ... so many medications. Once you have learned that routine it looks simple. During my orientation I was overwhelmed; I thought, "Oh my goodness I'm not going to work. I'm exhausted. I don't know how to do it. I don't know what to do." Now it's OK, I've learned the names of the residents, and every day I learn something new. Medication is so important and also the rules in this place. We're really overloaded; there are 65 residents and one RN. For 50 of them I give medications at least 3 times during my shift, and they are not getting just one pill; they are getting 3 or 4 or 5 pills so you need to know what you are giving. Teaching is also a big part of nursing. Residents will refuse medication; this is their right but if you teach them, explain to them, they will see the benefit.

I wish my language were better. I'm thinking of taking some more courses. I will do that as soon as I get settled. Right now I'm between places. I'd like to be able to express myself the way that I want to sound, the way I feel, the way it is, not in simple sentences that sound just like beginners. Giving instructions, receiving instructions is simple. No problem at all. Also with residents, I explain; I talk to them; that is simple language. I teach them in

simple sentences. I don't have any problems. In general, I would like to sound really good with a nice level of English, not beginners. I notice that my English is not bad but also I'd like to have better knowledge. I notice also my accent is quite heavy; I can't change it, I can't; I know that. Maybe it's with the families, I experience the most difficulty; how do I express myself when they ask for some explanation. I can manage but I'm not satisfied. I know that I can do better. I'd also like to take some advanced writing, but for a writing course I really need time to read and write and I don't know what to do. I prefer to take a course. If I do it on my own, I'll leave it for tomorrow, for the day after tomorrow; I'll just keep postponing. It doesn't work.

The residents where I am right now are also from Europe and they don't mind my accent. We don't have any problems communicating. I have a nice relationship with them. I know how to approach them. I had a nice experience during my practicum. I was on the medical floor and I had a resident with congestive heart failure that was assigned to me. When I went into his room, from the first moment I knew he was the type of person that tells you, "Stop. This is my intimate space. Don't come near. That's it. Stop!" after that, when I talked to the gentleman I realized that he was an army person and that was his way of being. I communicated with him nicely and I didn't have any problem. But you can feel it! If you are sensitive and experienced in nursing and in normal life, you can feel it.

The hardest part is talking over the phone and getting orders from doctors about medication. I'm always afraid that I will maybe hear something different. Last time I phoned the doctor back and I said, "Doctor, excuse me, I think that I didn't write it down correctly. Could you please spell it for me?" I don't like getting orders over the phone. I really appreciate it if the doctor does everything in writing. But here, many times you are on your

own; you are in charge; you have to phone the doctor; you have to talk to the doctor; you have to get orders over the phone. It's really exhausting. It's really so difficult. Last week I had a resident, the lady is diabetic, insulin dependent, she was vomiting, throwing up everything, with a fever running at 39. I gave her paracetamol. I phoned the doctor and had to leave a message. I phoned again, "Listen I want to talk to the doctor now! I don't need to leave a message. I need to talk to the doctor NOW! I need it NOW!" Honestly, I don't know what to do; she is vomiting, if I give her insulin she will go into hypoglycemia stage and then what am I going to do. This is an intermediate care facility. They don't have anything there, there's no IV, there's no drip, nothing. So the doctor answered; I explained and he said, "OK you can give her a gravol injection." I need to have his order! There are some nurse initiated orders for just simple stuff, paracetamol, gravol pills, but she's throwing up. So for an injection, for anything else I need the order! I prefer it when there are doctors around visiting regularly, like in a hospital. It's easier. If anything happens, there's a doctor. Here, you are on your own and to get a hold of a doctor, sometimes you have to wait and wait and I need him NOW! if I didn't need him I wouldn't phone him. That's the hard part. We are conflicted inside ourselves because we are used to having a doctor beside us all the time. It's not that we are not confident in ourselves; there are situations when you need doctors. I don't like it the way it's here. I don't like getting orders over the phone. It means all the responsibility is on our shoulders.

Working with nurses aides is also hard. I'm not a bossy person. I prefer team work but you will find situations hard to deal with. Nurses aides, care aides with long experience, are not happy if you ask them to do this or do that. They think you are giving them orders; they know what they are doing. I had a resident a few days ago who had just come back from a

hip operation; poor lady, she had fallen and fractured her hip. She was asking to be changed; the care aides wanted to go for their break. I asked them, "Please, can you change that lady before you go for your break?" They were angry. I'm sorry it's a matter of priorities. I told them, "Guys, I'm really sorry but ... it happens to me too. I move my break from the afternoon to late evening when it's busy, I will have my break when everything is done. It doesn't matter, half and hour earlier or half an hour later, big deal. We're here for the patient." I have done administrative and supervisory work before but it's different. Here the priority is breaks... I don't think so. It's OK with me to take breaks; really we need them; we are overloaded. but half an hour early or half an hour late, doesn't mean anything. That resident should get attention and care. She is wet! and she's just had an operation and she's all in bruises. I'm sorry... These last few days I felt two of them were always confronting me. Whatever I asked them, they were refusing me. Finally I said, "Wait a moment. Would you please tell me what is going on? Are you angry with me?" They told me that they felt I was being bossy, that I gave them orders. I said, "Guys, I'm really sorry that you took me like that. I'm not a bossy person. I asked you **kindly** to change that person. I am not telling you how to do your work. If there's anything that you want to talk to me, feel free, let us talk, so everything is OK." I'm the type of person who wants to clear things up. We are working together; we are a team; let us put everything on the table.

The process of being reaccredited as a nurse has taken me four years. I worked for one of those years, so it's been three. In that process I have changed my approach to patients. It's different. There is also a difference in my point of view. One example, back in my old country, we used to say to a boy when he hurt his elbow and he experienced pain, "Don't cry. You are a boy." Here you don't. "It's OK to cry" is really a different point of view. It's

changed, it's changed, it's really changed many things I believed. Why treat boys differently from girls; they have a right to cry; let them cry. The poor guys can cry, why not! why suffer and pretend to be strong; it hurts the same; so I accept it.

Oh, I've changed many things. I'm always ready to accept something if it's right; that's the way to learn and to improve. There are so many examples that I can give. I've changed my opinion about being supportive; it's really important to listen to people. If somebody wants to tell you something, listen; he needs to talk; she needs to express herself or himself. I learned, I learned, and really I'm glad that I learned.

By making the reaccreditation of foreign educated nurses possible, Canada is getting trained and educated nurses with experience and the nurses are getting another experience; they can learn North American ways. We bring our experience and we are building on it by learning something new; so you have really good nurses. By coming to Canada I've gained more knowledge and have updated the knowledge I had.

-from Korea -in her early 40s

-as a child wanted to be a reverend → a reverend's wife → a nurse (BSN)

-general surgical ward (3 ½ yrs.), dermatology, central supply (nurse in charge)

-left hospital work after marriage -part-time RN for company

-care of only child, a son (8 yrs.)

-temporary school health teacher and O.R. (2 mos. each)

-Full-time school health teacher (4 yrs.)

Mary

When I was really young, in elementary school, I wanted to be a reverend in the Protestant Church but I soon realized that girls in Korea were not allowed to be reverends, then I changed my mind to be a reverend's wife. As I got older, I realized that the role of a reverend's wife was very hard because she should not only support her husband but also the parishioners. In junior high school, in those days, most teenagers liked to read many kinds of books, it didn't matter what. I remember reading the biography of Florence Nightingale, and while I was reading the book, I almost cried because of her sweet heart and her caring attitude towards others. I was really impressed by her, and thought that being a nurse would be easier than being a reverend's wife. So, from then on, I had a clear idea of what I wanted to study in university.

My first choice for university was a Christian university with a very good reputation but I failed the entrance exam. I hadn't expected to fail. Before, I used to be the type of person that liked to help others but I was so confident about myself that sometimes I was egocentric. Failing actually helped me be more flexible My family wanted me to study

another year and try again. I didn't want to spend my time and my parents' money, so I chose another university.

While I was learning about nursing I became more confident about the choice I had made. This was really what I wanted to be. I enjoyed studying itself, but even more caring for patients, the practicum experience. I felt that after graduation I could work for people and also earn money using my profession. That made me feel very good.

After graduation, my father really wanted me to go to the United States to study more; he believed it was the best place to study nursing but I really wanted to be with patients so I told him, "No, I really want to be just a nurse." I applied at the university hospital and was hired. Twenty years ago, my old university hospital had more advanced facilities and was better organized than hospitals here. I was hired to work in the newborn unit, but in my mind, I thought a nurse should be able to communicate with patients; just caring for new a born baby did not satisfy me. So I turned down that offer and accepted one working in the general surgical ward. I worked there for three years and six months.

All new graduate nurses have the care of patients uppermost in their minds when they start, but as days go by, their attitude changes. Some think of their job only as a way to make money. While working with that kind of nurse I came to realize more and more that I wanted to continue taking care of the patient. During that time I learned a lot not only about nursing but also about organizational skills and dealing with others; that is the most important thing.

The dermatology department nursing supervisor recognized my ability to deal with people. That was the reason I was assigned to the outpatient department. I was the first RN to work in that department. I had to supervise the nurse's aides; interact with them and with doctors; and relate to the administration department.

In my days, a regular registered nurse couldn't work after marriage. The supervisor in the nursing department knew I was getting married, so I was promoted to work as a nurse in charge in the Central Supply Room. Work there demanded something different again; there were more and more nurse's aides. Sometimes if nurse's aides wanted to give me a hard time, I had no choice. The first two months I was eager to learn. But every operation had different equipment, so much equipment, and I was responsible for other people's work. If there was a mistake I was the person responsible. After two months, I got bored because I thought to myself, "Oh, I'm the person who wanted to be with patients, not with things. Here I'm a mere worker, not a professional!" But I still enjoyed working in the hospital, so, I just carried on with my work because after getting some experience in the Central Supply Room I could transfer to other units as a nurse in charge. However, my husband, my future husband, did not want me to work; he wanted me to stay at home, not just stay at home, I could enjoy myself by taking courses, but he did not want me to stick to the hospital and just follow the schedule; he didn't. At that time I had only two shifts, no evenings, but he didn't want me to work. I tried to persuade him but he was very strict about it, so just four days before the wedding I couldn't persuade him anymore, so I quit my job, yeah....so..... and then after marriage I worked as a part time registered nurse for a company, like an occupational nurse, but it wasn't a full time job, only two days a week. If they had some trouble, or if they wanted to arrange for a medical check-up, I went there. It was really casual work. During that time, since I also have a teaching certificate, I taught nurse's aides about public health. I enjoyed the teaching because their goal was to work in hospitals and I could share my hospital experience with them.

Then I had my baby. For me, taking care of the baby was our priority, so I quit my

job. I just took care of my baby, my child. I have only one child. During that time I just did my church activities and learned flower arranging. I just enjoyed myself. When my son was in grade two, one of my professors called me. We were alumni from the same university and had met through our involvement in the association's activities. She was upset with me. Before, she had seen me as being a very hard-working person but I quit my job and she was not satisfied with my attitude. She suggested that I work again but at the time, frankly speaking, I was very scared because I had been away from work for about eight years. I told her, "Oh, I couldn't work, I don't have any experience." She offered me a two-month contract as a school health teacher replacing someone on maternity leave. The school was a junior boys high school. I discussed it with my son and since he really liked teachers, he encouraged me to work. After getting permission from my son I discussed it with my husband, he was upset because he thought my son was not old enough to be by himself but I persuaded him because it was only for a two-month period and the school was not too far from my house. I was very excited; I learned a lot. In my old country, working as a school health teacher is like being a community nurse here but the system is totally different. Here a community nurse goes around several schools but in my country the school health teacher belongs to one school, usually with more than fifteen hundred students and more than one hundred staff; it's totally different. I had my own room and sometimes I taught public health, sexual education and environmental education and sometimes I did research, conducted surveys. But it was a pretty relaxed job.

So, after two months my job was finished. Some days later, my former head nurse called to offer me work as a nurse, a registered nurse in the operating room for someone on maternity leave too. Working in the operating room scared me because I had only one month

experience as a student nurse. She assured me I would manage just fine. The main reason I accepted the offer is that the hospital was very near my house and I had worked there before. I persuaded my husband, "OK I just want to see the new operation procedures and the new equipment. It's my interest." I got permission because it was only two months. While I was working there, the nursing director asked me if I wanted to work as a school health teacher, a full time job at a girls' junior high school, an easier job than a boys' junior high school because sometimes boys have a tendency to act very violently. I went through three interviews and got hired. I worked there four years before immigrating here.

Working as a school health teacher is the dream of the older nurse because they have a fixed schedule from 8:30 am until 4:30 p.m.; they can have holidays; and specially in my country, teachers are very respected by students and parents. My son had been doing very well by himself and I had some friends in the apartment where I was living who could take care of him. The school was on the way to my husband's company so we could share the car. Everything was perfect for me.

I liked working as a nurse, that's why before coming to Canada I thought I would be a nurse here too, but when I arrived I was mainly interested in enjoying myself. I really wanted to improve my English. I knew I didn't have any problems with English grammar. From junior high school we have English class, but the teachers are also Korean, so we don't have the opportunity to speak. We read books in English; comprehension is excellent for all Koreans but spoken English is terrible. My husband and I were looking for a place where we could study for free, like LINC classes. We had information that if we spoke fluently or if we took the exam very well we would miss our chance to study free. I heard from others who attended LINC programs that they had the opportunity to visit the Legislature and other

government offices so they could have a general idea about Canadian society but I didn't have that kind of opportunity. Once they heard that we graduated from university they thought we could speak English fluently. That's not true, we know basic grammar and our written English is OK but spoken English and Canadian culture are also very important. Even though my husband and I pretended not to speak well, they recognized that we didn't have any problems with simple English. So, we were not allowed to study.

My husband and I looked for another place. We found one with classes in spoken English but not intensive. Later, through the continuing education booklet, we found out about an adult learning centre in a school in our area. There I finished English grade 10. I learned how to speak in English, oral English.

Before immigrating here I wasn't worried about my English. I had been here three times. So, during those visits while I was shopping I thought, "Oh! I will be OK." I thought like that, but just being a tourist is totally different from living here. Most people here are very gentle and very polite, but others understand what I want to say if I want to spend my money to buy something, but when I need some help, they don't understand; they are impolite. Just coming here to spend money is totally different from living here as an immigrant.

The grade 10 English course was very good because we prepared something and then we could talk in class while learning Canadian history. It was great. After finishing grade 10, I enrolled in English grade 11. However it was totally different; it was for Canadian born people. Tutors were always there to help students but students studied by themselves. So, I read many novels, poetry, some articles but just by myself. We ESL people need more conversation than English grammar. I want the government to hear our voice; once they

accept immigrants, they should provide ESL courses.

While I was studying for English 10, my husband dropped the course because he is the one who should earn money and he had to see what he was going to do. My husband is a computer systems analyst; we were independent immigrants.

I was thinking about nursing at that time but I felt that learning how to speak was more urgent. During that time, I did contact the RNA and found out that all my documents which I had prepared were useless because they were not delivered directly to the RNA from my school, my government and my workplace. I didn't have any hard feelings at the time, even though I thought things would be easier. I asked my friends, my relatives, my alumni, to prepare the documents for me and to have them sent directly to the RNA. It would take a long time. Finally the RNA sent me a letter: "All your documents show you don't need a refresher course," because if we had work experience within the last five years they didn't require us to take a refresher course. The letter also said that I needed to pass TOEFL with a minimum of 550 and the TSE score at that time was 200.

Then, I applied for the ISA course, but I was so ignorant about Canadian society at that time. When I applied at ISA, the program manager in the interview told me there were many applicants waiting for the program who had applied many times. She told me my English level was high enough for me to study for the TOEFL by myself so I just accepted her recommendation and thought I would do that. It was a big mistake! It is very difficult to study by myself! If I attend a program I study very hard, otherwise, I just enjoy myself. I finished grade 10 and then I enrolled in grade 11. But I couldn't concentrate. I was feeling the urgency to be an RN again. When I came here I thought I could be an RN within one year. Time was passing, two years already, so I decided to apply again at ISA and that time I got

enrolled. During the course, I passed the TOEFL at first try but I failed the TSE. Even though nowadays I'm a very flexible person, I am a very strict person when it comes to following rules, all the rules, and I had a misunderstanding about the TSE. While we were practicing the TSE, we learned that there would be a sign to start and stop, so during the test, I waited for the signal to start but it never came. I missed some questions and then I misunderstood others. I got a really low score, 35 out of 60. At that time the TSE score was changing. Before, the RNA required only 200 out of 300, that meant 66% was enough but when they changed the score to 50 out of 60 it meant that we needed more than 85%. So, that was a big difference. The TSE, I think, is a ridiculous test. What else can they use?

After finishing ISA I applied for the refresher course even though I was not required to take it. I didn't feel confident. I needed some more knowledge about Canadian hospitals. However, I was not accepted because of my pronunciation. The program manager told me my pronunciation was terrible; she couldn't understand me. Then I thought, "OK, I will study by myself to prepare for the CNATS" but it was very difficult, because I was also required to be a housewife, a wife, a mother and also a daughter; my parents live near my house. All my roles hindered me to study, to concentrate on studying nursing. So, after one year I applied again, and I got enrolled in the program.

The nine-month course at the college was a really excellent experience for me. The first two months we learned therapeutic communication. It was very new for me and also I thought for the other immigrants. Working as an RN here, one is responsible not only for taking care of the patients' health but also for how to approach them. It is very different. For example, in my old country, we never told a dying person, "OK, you don't have much time. You should prepare yourself," we **never told them like that.** We just pretended. Even

though the family members were given the information, the patient himself was never told. Here it's totally different. We should provide them the information to prepare for their death by themselves. I learned that very basic idea but most important for me.

In therapeutic communication, we also learned the difference between empathy and sympathy. Before, my attitude towards the patient was one of sympathy, not empathy but I learned. I learned a lot of ways to approach patients, depending on their age, their situation. Once I knew about this type of communication, I also knew the terms I should use, the terms for reflecting, clarifying. You should never use closed questions, always use open questions, for example, "Did you eat lunch?" is a closed question. "Yes" or "No," I can't expect more response from the client. "What did you eat for lunch?" is the open question.

It was not only spoken English; we learned also body language, physical touch, nodding my head, showing willingness to help. It's very different. Here if we touch somebody, it might be seen as harassment. In my country, we women hug and hold hands while walking but here if a woman holds another woman's hand somebody might think they are lesbian. It is scary. The first two months we didn't have any hospital experience; we just studied therapeutic communication; we practiced with each other. I use it in my actual life too, in my married life and towards my son. So, still, therapeutic communication is an excellent experience for me, the best.

From the third month on, we went for hospital experience. Of course, before going there we had lab skills at school. The school has a nursing lab where we learned nursing skills and demonstrated them among ourselves under the instructor's supervision. We just learned using different methods, using different equipment but learning nursing skills is not difficult for us since we had experience.

Frankly speaking, what I worried about most was my spoken English. When I came here, at first, I didn't worry; I just spoke whenever I met Canadians but after getting the comment about my pronunciation, I was a very scared. So, before enrolling in the refresher course I devoted myself to studying pronunciation for more than one year at QVC evenings. I combined it with grade 11 English in the daytime. So, for one full year I attended that course and some other college preparatory class. I spent my time and my money to improve my pronunciation. So, even though at first I hadn't worried, after getting that comment from the refresher program manager, whenever I wanted to speak I kind of hesitated because of my pronunciation. But, the first week, just the first day of hospital experience, was **great!** The patients understood me. I explained to them, "I know my pronunciation is not good for you, so, please, don't hesitate if you don't understand me; just tell me," but all of them encouraged me and told me, "Oh, you are great. Your English is OK" and "Oh, if I were you I wouldn't be able to speak your language." They were very supportive. I think it's also because they could read our hearts, our sincere hearts wanting to take care of them even though we had some English barriers. The English barrier is not a real barrier at all because we have a definite idea about nursing and we have good experience; we can help many people. I think maybe because I'm not young, I know how to deal with people. Through the experience of raising a child and having experienced a lot of things, I think that even though I have a language barrier, approaching patients is not difficult for me.

At the same time we had the practicum, we also had preparation for CNATs. Preparing for the RN exam was a great thing too. However, I think having a practicum in different hospitals was more beneficial for me. The other thing was that I got some idea about the care of the elderly. Now-a-days long term care facilities are expanding compared to

acute care. Here, being in a nursing home is very natural. In Korea, we don't have that concept. Having a practicum at an extended care facility gave me a clear sense of it.

Having friends from other countries is also a very important advantage of the programs. Canada is a multicultural country, that's why it's important to know about ethnic backgrounds and what culture is.

My English course at the college emphasized TOEFL preparation. It was just using textbooks for English grammar.

I finished my practicum in May last year and took the RN exam in June. The exam is the same for all applicants, ESL or not, that's why ESL people have difficulties to read all the questions, almost 300. After finishing my exam I checked over my answer sheet; I counted the questions I was not sure on; there were too many. I had no confidence I had passed. If it were a test just based on knowledge, not psycho-social knowledge, it would be OK. I thought for Canadian RNs it would be easier because they know their customs, their culture and the special terminology, but actually, I heard from an RNA officer, that it is not the ESL people who fail the exam.

I waited one month to get the results. During that time everybody asked me about the test, specially my church mates who were praying for me. Then I got a letter; it says only "Passed;" it doesn't give any score; it just says: "Passed." I was very happy because when I started to study, some Koreans told my family that they thought I couldn't do it. Among them was a couple who has a daughter who finished UBC nursing school and is very proud she passed the RN exam. They told my husband and my brother, "It's very difficult;" they told them that I'd be better off studying some other thing, working at something else. Because of that, I was very happy when I passed.

While I was waiting for the exam results, I got a call from a Korean church-mate. She asked me to take care of her father. The father had been admitted to the hospital and had been diagnosed with Alzheimer and Parkinson disease. He was ready to be discharged but the hospital and the doctor recognized the heavy workload for his family members so they recommended a home support worker. The daughter asked me because they could not find any Korean home-support worker, so because I've known the family since coming here, I accepted her offer. I thought it would be good for me to have a general idea about what home support workers were, and also have the opportunity to meet other professionals in the field. The personnel officer gave me an orientation to the duties of a home support worker. I would be in charge of personal care, which means bathing, shaving, some meal preparation, cleaning and laundry for the client, not for the family members. I've been working as a home support worker since then.

At the time, I thought I would work for only one month, but in July and August, I had guests from Korea. Because of the regular schedule, I could serve my relatives from Korea; they stayed in my house for two months. After that, in September, I thought about applying with hospitals to work as an RN. However, I heard from my classmates who are working for the hospitals that they work as casual nurses so, when they call them, if they have time they agree to work but it's very difficult for them to have a regular schedule, to have their regular lives. I am volunteering as a Sunday school teacher; usually they call casual nurses for weekends because regular duty nurses don't want to work during weekends. That's why I hesitated to apply for work at the hospital. Also, I can get some medical and dental benefits through this home support job so I thought, "OK, I and all my family members can take the medical, dental benefits, so I will keep this job."

The other thing that happened was that the home support association advertised for a position as supervisor. I applied and had a first interview. Then they called me to tell me that the full-time regular position had changed because of government cut-backs. I decided to leave my application in but they hired another person who already had supervisory experience. That's all my story up to now.

The reason I applied for the position is that my community, our Korean community, doesn't have information on home support care. Even though some Korean seniors can't manage, they struggle by themselves. Family members can't leave their parents alone, but here they have to work and they have to study too. So, I planned to have a seminar for the Korean community about the job of a home support worker, to recruit more Korean home support workers. That's why I was interested in applying as a supervisor but I was not accepted, and I can understand why I was not accepted. Working as a supervisor requires a lot of spoken English; most of the job is done by phone. I know my English limitations.

I actually have a kind of conflict about what to do next, whether to work in an extended care unit, like in a nursing home, or work in an acute care unit. Some of my classmates working in acute care told me they have a lot of stress because they get calls from doctors and they have to call doctors. Sometimes they can't understand but they can't say "Pardon, pardon" all the time. That's the most stress for them. They also told me that if they were me, someone in their forties, they would not work in an acute care facility. The reason they do it is to have more experience but since I already have worked at various facilities, they recommend that I work in extended care. I know that work in extended care is easier than working in acute care not only because of language but also in the acute care unit you do everything by yourself, while in extended care you have nurse's aides who help you. It's

heavier physical work in acute care and more supervising work at the extended care unit. What attracts me to acute care is that I'd like to have more experience. I'd like to test my ability, see if I can do it. I want to challenge myself and at the same time I want to relax. It is a conflict.

Another conflict is working on Sundays. I don't know! I don't know how to decide what to do. If they ask me to work in a Sunday I will refuse but I know if they call me again and I refuse again and again they will not call me any more. I heard that from my friends. They told me if I want to work as an RN, I should forget about Sundays for a while and then later when I have seniority, it'll be OK to change shifts. I can't decide but I know I should work as an RN; that's why I plan to quit home support. I need the money, not only the money, but also, I'm an RN right now, so I should work as an RN.

Now I'm not sure because I have worked for too long as a home support worker. I think of myself as not very diligent. I made myself too comfortable. I don't need my brain too much for this work. That's why I'm not satisfied with myself at this moment. My patients in the practicum understood me but now I don't have confidence; I don't. Day by day I'm loosing my confidence, specially in pronunciation. Now with my Korean client, I don't have the opportunity to speak English. I'd like to attend again a pronunciation class at QVC. The class is only two days a week so the other days I can attend another class to improve my English in presentation skills to speak in front of people. I know there's a course.

Actually, I haven't changed as a nurse but I have more knowledge than five years ago. I also realize that I'd like to study more here. I'm interested in working as a community nurse. I don't know, it sounds ridiculous. I always think about my community, the Korean community. While working as a home support worker, I've met some home care nurses; they

are very happy with me because I can translate and I understand what to teach the client. So, if I worked as a community nurse I could help my Korean community, and it would mean also helping this Canadian society.

-from Iran -in her mid 40s

-as a child, wanted to be a nurse -2 yr. Nursing diploma -BSN

-specialization in hemodialysis -hemodialysis unit (4-5 yrs.)

-married pediatrician

-specialization in pediatrics -children's hospital (17 yrs.), staff nurse, O.R., director of care

Nahid

When I was a child, I got sick and went to the hospital. That was the first time that I saw an RN. I decided after going home that once I grew up a little I would be a nurse. I was in hurry because I really loved the idea. First, I got my diploma in nursing through a two-year program after grade nine. Then, I found that I could study more nursing and I decided to go for my B.S.N. I went back to school, I finished grade twelve and then four years of university. I took the nursing exam; it's the same all across the country; it's very difficult. After I finished my four years of university, and because I was the top student in my course, they offered me one year of specialization in hemodialysis. I was young; it wasn't difficult like now that I got my R.N. in Canada.

After that, I started working as a specialist in a hemodialysis unit. After a while, I changed my career because I married a pediatrician. My husband wanted me to work with him in his office and in his hospital. We had 180 beds. I worked more than 17 years in the pediatrics ward of a children's hospital.

Because I had my RN, it didn't matter where I went, I could work in the surgical ward, in pediatrics or wherever, but for hemodialysis you have to have a specialty. When I

changed hospitals, I preferred to know more about children and their sickness and so I took an extra six-month course and became a specialist in that field. It wasn't difficult; it was easy; I really love children.

For me the change was lovely. After four or five years working in hemodialysis I was depressed because most of the residents don't have any hope to live long. Children were full of life. It was a big change. I enjoyed that.

After 17 years, oh, my God! I don't know if I made a good decision. Right or wrong it was really difficult. Actually, I made the decision to move because of my children's education. We had a very bad time during the revolution and the war. All universities were closed for four years; it was at that time that I made this decision. My older son was fifteen, fourteen and a half years old. Because of the war, boys could go overseas until age fifteen. After that, the government didn't let them go out. I thought "What can I do in case anything happens to my country and the university is closed again." Before anything worse happened, it would be better to go somewhere else! My husband went all over Europe, visited five countries, the States and Canada. It took him three months just to study where it would be better for us. Finally, he decided to come here because one of my sisters and her family were here. We decided to come and we just hired a lawyer. It took one year for us and a lot of money to pay for everything.

At the time I left my country I was matron of the children's hospital, the highest position in the hospital. I started as staff nurse. I worked three years in the operating room, and then I was supervisor of the hospital for about ten years. Because I had a lot of experience, I just started working as matron. I don't know what they call it here, coordinator,

no, director of care. Here the highest level of nurse that is responsible for all nurses is the director of care, so I was director of care when I left.

In our culture, our parents dedicate their lives to their children so for me the main thing was my children's success. I said, "OK, it doesn't matter if I start from the beginning as a staff nurse. That's fine, because I love patients, I love children, I love people." First of all, my aim was helping people and at the same time helping my children to become educated. Actually, at that time I didn't think that it would be difficult like I feel now. I thought maybe it would be easy. Nursing is nursing it doesn't matter who is sick, you just give care. I didn't think about the different culture, different behaviour, different communication. It's different just mostly in communication. For example, in my country if somebody has cancer or a very difficult illness, you don't tell the patient, you go to the family and inform them first. If they want, they'll let the resident or patient know. But here it's different. So, it was really a shock for me.

I started first, having to know English so I could communicate with people. I came here August 1993. I went to QVC from the beginning. When I arrived, I just settled my sons into school and then my husband left us here and went back to my country because we found that for him it was impossible to work here. We needed support, so he went back to work and we stayed here. He would come two months, three months here and go back again for four months to do his job and support us, bringing some money, selling one of our properties. It was difficult but I started from the beginning to go to QVC. There was a long waiting list. So, it took me about six months. At the same time, I went to Martin Centre. It's an adult education centre. I took some courses there, actually it wasn't useful but it was better than

nothing for me. It was just conversation and at that time I was in a hurry to learn more English, but it was impossible, all the colleges had long waiting lists. I was told that the best place was QVC. So, I waited for about six months. At the same time I was studying by myself, watching TV, listening to the radio, talking to people and I was looking for volunteer work.

I wanted to communicate with people, Canadian people, to know language, to learn how to speak. I wanted to know something about their culture. At the same time, because we're a big family here, my sister, my brother, me and I thought that if I stayed home, I wouldn't learn English, so I had to go through something.

I found a place, it was a day care for adults, for seniors. They had many activities there. I volunteered once a week for more than two years. I started volunteer work at that daycare for two reasons, one, the main purpose, was that a group of nurses went every Wednesday to that place and I wanted to meet the nurses and through them to see how I could find out about getting my RN here. Secondly, I was told that elderly people would talk more than young people; they have free time so, they're more available than young people. Those were the reasons. The main purpose was to be able to work.

I talked with some of the nurses there. They actually didn't know how I could become an RN. Even Canadian nurses couldn't help me, but it helped me just to communicate with people, to know a little language, to improve, because I was shy. For young people, for children, it's easy to talk English. It doesn't matter if they pronounce correctly or not but I think for adults it's not easy. I used to think, "If I say something wrong, oh, people will laugh at me" and I was shy, so, it helped me because I talked with elderly, I listened to them.

I already knew some English because in our country when you go to grade seven in high school you start English and then continue throughout university, but it's not much English; it's just four hours a week. Actually, four months before coming here, I went to private school too just to remember some English, because I hadn't used my English since university so I had forgotten everything.

It was a great help for me going to work as a volunteer. I met one elderly couple, who I sometimes visited in their home and other times I invited them to come to my home, just for speaking. It was great. They were a Polish couple. At that time I thought, "Good for them, how well they can talk.," but now I think my English is better than theirs.

On Wednesdays, a group of retired nurses went there to help the elderly people, to check their blood pressure, give some instructions for medication that they were using, encourage them to do some activities, give emotional care and assess disabilities that some of them had. I would check their blood pressure too and do some massage following directions from the nurses that were working there.

The volunteer retired nurses were very helpful; they were very nice and they encouraged me. Even though they didn't know how it could be done, they encouraged me to get my R.N. I don't know they liked me. They're very nice.

I didn't find out what nursing was like in Canada until much later. Even when I took the course at ISA it didn't help me to find this out, actually just a little because it was a very short time that we had communication skills, but at the college, the Refresher was really helpful. We worked two months full time just on communication skills. It was really helpful. I found that out there.

When I was volunteering I found out that I had to pass the TOEFL and the TSE. I registered with the RNA and they accepted all my courses. Some RNs from other countries need some other courses like pediatrics, psychology or gynecology but I didn't need any extra courses. I was assessed and I was accepted to the Upper Intermediate English course at QVC. I started Upper intermediate then Lower Advanced and finally Upper Advanced. After finishing Upper Advanced, I took another course, it was just for health care people. It was the same as the Upper Advanced level but with vocabulary or some subjects about health care. It helped me a little to improve vocabulary about health care. That's all.

One of the elderly people in the daycare program was from my country and she said that her daughter took the course in ISA. I called her and she told me "Yes, there's a course at ISA, we can take this course, it's helpful." At that time I thought maybe this course was the Refresher course. I was disappointed when I took the ISA course. I was always complaining because my expectations were higher than what the course could offer. I thought that maybe they would prepare us more, because it was eight months long. It was just preparing us for TOEFL. My understanding was that they would prepare us to write the exam, the board exam. Actually, I needed to improve my English because I still had to write the TOEFL exam.

I though it was the Refresher and it wasn't. I'd made a mistake. I didn't quit that course when I found out that people like, for example my English teacher, were in contact with the people from the Refresher course. I thought, maybe if I quit this course, they will think that I am the type of person that won't take things seriously. I **really** needed the course. Actually if RNs don't work five years, they have to take this Refresher course. For me, even

though I had not been away from nursing for five years, it was really important to take the course. I thought that maybe I could learn more about nursing here in Canada, so I wanted to take that course too. That's why I stayed in ISA to finish and then take the Refresher. At the same time, I was studying for TOEFL, to be able to pass the TOEFL exam.

Learning English was the first step. I thought, if I can't communicate with people, how can I understand their problem, how can I write the exam? Even if I passed my board exam, I still had to understand people and they had to understand me. It wasn't difficult to write the exam because I know all nursing and I was so confident that I could write my exam. It's just reading the book and I can pass the board exam but at the same time to become an RN it is really essential to understand the resident, the people there, the sick people. So, it was necessary to learn English first and then other things.

ISA helped me to know about the TOEFL exam in particular. We were working a lot on this, but at the same time, we had some classes that I think were not necessary for that program. For example, the guest speakers and the job finding. Actually, it is important but if I have to pass TOEFL, I have to learn English first and then go and find a job. Job finding was for people that did not really expect to pass TOEFL and be RNs here. They might work as a care aide. It was right for them, important for them, but for people like me whose aim was going through the exam to become RN, it was a waste of time. I wasn't happy.

The guest speakers were not useful either. There was a group from the RNA who came and asked us to put our name in to participate in some of their committees and they would let us know when or where we could go. They didn't follow through; they just came, showed themselves and left. All things were against us RNs.

We also didn't need all those classes with the nurse, because everything got repeated again at the Refresher and I didn't learn anything from her. For example, she was giving us one hundred questions to write as an exam. It took us three hours to sit and write the exam for RNs, not having studied any nursing in that course. It was a waste of our time. Even after the exam she didn't go through the questions. Why, for example, my answer was not correct, why this other one was correct.

I was the top student in that class and the instructor was surprised. I was the top student, and I got 30%. So it was in some ways putting down the RNs. Most of the questions were psycho-social and based on communication skills. When we asked her to just give us the reason why a question was wrong, when for us, with our culture we were sure that the answer was correct, she said, "Different culture. You have to study." But how could we study, from where, with all the books we had, a beautiful library, but we didn't use those books, because we didn't have time and we didn't have good direction on how to study. I felt very sad, very down, very nervous; not only me, all of the students in that course felt the same. I know some of them were crying later, "Our instructor is just putting us down." It was kind of sad. I didn't quit. I said "OK, I will go through the right way to find out how I can become an RN here." After taking the Refresher course, it was easy for me! I was very proud of myself then. It's easy, it was really easy to write the exam.

The ISA course helped us to communicate with the College, to find out how we could register. When I finished ISA I went to QVC again. I was reading slowly; I decided to improve my reading skills to pass TOEFL, so I took a writing course and a reading course at the same time, evenings. I was also studying by myself at home to be able to pass TOEFL. I

registered for the Refresher. The manager called me and told me that my TSE was low but that I should go for an interview. She invited her English instructor for an interview and at that time they accepted me.

Even though I didn't need the Refresher, I wanted to go through the nursing materials. I wanted to be familiar with the questions, with the format for the nursing exam. I wanted to go to a hospital, to see a hospital, because I was not able to do volunteer nursing there on my own. I was told, "No, you have to take a course and as a student come to the hospital to work, to follow the RNs, to see what's going on here." So, that's why I decided to take this course; to be more familiar with equipment here, and the way of treating people.

I was so happy. I was so happy I got accepted into the Refresher, because only 21 students were accepted in the whole province. I was one of those lucky ones. All the students that pass this course will pass for sure the board exam. If you can't pass TOEFL, they can't do anything for you. If you pass TOEFL, you can pass nursing. We had one of the best nursing instructors; she was wonderful. She was also the coordinator of this course for nine years. She instructed us perfectly. She guided us on how to study. It was **really** difficult, it was tough. When she was interviewing me she said, "Nahid, this course is really difficult. Do you think you can handle it?", I said "Oh, yes, of course. I have time, I can manage, sure I can. My children are old enough to take care of themselves. My husband is here to support them." After this course started, I said "Oh, my God, it's impossible. How can I manage all these things?" I had to travel two hours to school, everyday, sometimes three hours, driving, driving. It was really difficult. Sometimes I was asleep on the road. Anyway, I survived. I was happy because I was learning. When I was reviewing my nursing I enjoyed it a lot.

Nursing is nursing. Only communication was different and language skills.

For me, TOEFL was the hard part but not nursing. I got 535 after finishing the ISA course. I wrote TOEFL three times and on the third time I got 535, that was acceptable for the College to take the Refresher course. And then on the first TOEFL after taking that course I passed it. I got 560.

TSE was difficult for **all** of us. We had a student from Germany in the Refresher. She was perfect in English; she had been living here for twelve years. At first I thought she was Canadian because she was white and she looked like a Canadian. She got 50 from 60; 50 from 60 is the passing score for the RNA. Because we were 21 students our instructor took some of the students that she thought were perfect and could pass at their first try. There were five, just two of them passed. Our instructor was disappointed. The TSE had just changed; the requirement used to be 200 out of 300 and the questions were easy, but for us it was difficult. Everybody used to pass. There were two former graduates from the ISA program that had passed the old TSE but were not able to pass the TOEFL until the end of the course.

The Refresher was really hard but all of it was useful. We were enjoying it at the same time as we were studying. It was tough but we were learning. It wasn't like TOEFL. You have to study for the TOEFL exam but maybe you don't use it. Everything we studied in the Refresher was useful and now we need it. All of this we had learned in school but it was twenty years ago. When I was working I had experience in my area, children's hospital, children's diseases so some of the diseases for elderly or for some other area I was not as familiar with. The Refresher was a review for me and I learned again. Actually nursing changes over time, there are changes taking place every month, every day.

The Refresher program was important because without that course it was impossible to pass the board exam. It was a really good course. We covered all we had to study for the exam. We studied Communications for two months every day. The clinical experience prepared us to work as a nurse. We learned the behaviour of hospitals. We had the experience of working with equipment, it was a little bit different from my country.

After I passed the board exam I needed some rest, so after two months I put in my resume and two weeks later they called me and I started working at a care centre. I'm still working there and at another centre. I didn't want to work in a hospital. I prefer to work with the elderly because before that I worked in a children's hospital and I think there are similarities between the elderly and children in some areas in that they both need more care.

When I first started working it was a little stressful because one day I had to work in extended care and then the next day I had to work in intermediate care. After a while I got to know the different residents and then it was easy but the first few months were very stressful. Now it's really easier than working with children because with the children there were new ones every few days.

Here they have a different approach. It's very different from my country. Now, after two years, I have no problem, but before that, yes it was difficult. In my country when I enter a place where there are people, for example if I enter the nursing station and some nurses are there, it's my duty to say "Hi," but here some of them do and some of them don't. At first if I was in the nursing station and somebody came in to the office and they didn't say "Hi", I would feel, "Oh, maybe they don't pay attention to me," but now I know they have different customs than mine. Now I accept it; even if they are the ones coming in, I will say

"Hi." At first I thought, "Oh. maybe because I'm foreign they ignore me."

I think I was more satisfied in my country because of the English here and because the culture was easy for me there. Sometimes now I have problems. I don't know what I can say to support residents emotionally. What can I say to them so it will be easier for me . What kind of communication do they like? Most of the residents in one place are Canadian, while in the other place they are Chinese. That is a barrier because most of them don't know English; they have to have translators. During these two years, I have come to understand their culture and because I know the residents now, if they talk I know what they want, sometimes, not all of the time.

I'm not that different from what I was before, I have more experience and I speak English now better than before. There's a difference in culture between residents here and in my country, but nursing is the same. Here residents have more demands than in our country. They want better care, specially in the area where I'm working, the care of elderly people. We don't have this kind of facility in my country because usually people keep their parents at home; they don't place them in homes for the elderly. There's really nothing to learn as a nurse it's just that the system at home is different, we don't have this kind of facilities, but here the government pays for them. The nursing is the same but the culture is different. I hope, think, I have changed, I have to .

-from El Salvador -in her early 30s

-as a child and teenager, wanted to be a doctor → war/marriage → nurse, BSN

-worked briefly as community nurse in research

Violeta

My name is Violeta. Ever since I can remember, I wanted to be a doctor. Sometimes in my backyard when there were dead animals, like birds, I would take them and open them up, open each organ to see what was inside. Or, I would pretend I was a doctor taking care of everybody. When my dad took a "siesta", a nap in the afternoons, I used to go to his bed and put a towel on his forehead pretending he was sick with a fever. I wanted to be a doctor but because of the war I wasn't able to do it. The only choice that I had, close to my house, was the school of nursing. My parents were eager to see me study there because it was a "female" occupation.

Nursing was interesting; it was something very close to being a doctor. I really loved to do assessments, to try to investigate further. I was good at it. I was thinking if I didn't get married, I would go back to university to study medicine, but my plans were frustrated by the war.

At the beginning, I didn't get along with my classmates. I was too much of a perfectionist. I wanted everything in a particular way and I pushed too hard. We were just females there; it was kind of boring. I had to adapt. The first year of the program was just basic nursing; the second year went into more specialized areas. I delivered a few babies. In O.R. I got to see what they were opening; that was exciting! The third year included

Administration, preparing to be a head nurse. I enjoyed that as well as the Community Nursing I did on the last year. At the end of my studies, I kept working as a community nurse and then was hired as a research nurse. We traveled and studied the needs of people all over the country. There were so many issues; the list would be too long to include here. Community Nursing was something I wanted to continue doing; in fact, it's something that I have in my future here as well. There is a large Spanish-speaking community here that needs somebody that can understand exactly what they say, how they feel, not translated from English to Spanish, but just there, in their language.

I emigrated from my country in 1988 after I got married. My husband and I went to the States first. It was a shock for me because I didn't know the simplest words like "sell." They put me in a second level class right away, not a beginners. I don't know why, maybe because in my country I had some high school English, but when I was in that class I was frustrated; I couldn't understand anybody. I remember I had a Chinese classmate next to me; we would laugh at each other because neither of us understood what was going on, but we used gestures and that was the beginning.

I left the ESL class and went to work. I found a job as a nurse. My husband encouraged me, "Do what you were educated for. Don't do cleaning. Do something that will keep you in the field." He knew that it would open doors for me in the future. I helped a lady who had multiple sclerosis with her hygiene care, bathing and some exercises. She couldn't talk; I had to use the dictionary forcing me to learn words.

A month later, I found another job with an Alzheimer client. It was hard to communicate with him due to his confusion. His daughter knew a little Spanish. When I

needed help she used her one or two words in Spanish, but most of the time we communicated in English, sometimes even in writing because I didn't know how to pronounce certain words. "Spanish is close to English and I just need to learn the endings," I would say. Many times it worked but other times it was totally different!

I found another job through the newspaper looking after a premature baby. He was still on oxygen. The mother offered me the job but I decided not to accept because I felt my English was not enough to handle an emergency. He was so tiny. No, I said no!

I got another job offer from a Spanish nurse that used to be an instructor where I had studied. I started working in the nursing home where she was a supervisor but seeing the abuse there, I quit two weeks later. I had my ethics ingrained in my heart and in my brain. For me the patient came first. The job would have probably helped me get into nursing quicker. My acquaintance was planning to help me, to guide me as to how to become a nurse.

I think a month later, I left Los Angeles. I didn't like the place at all, there was so much crime. We decided to move to San Francisco. Over there I knew that I had to get a job to learn English. I went to school but it was boring. I was afraid; I wasn't learning as quickly as I wanted to. If I turned on the radio I couldn't understand what they were talking about. I needed somebody face to face and to use gestures to understand what they wanted to tell me. So, I applied to work in a doughnut store. I knew that there I would be talking with the public. I pushed the manager to hire me, "Listen, maybe I don't know much English ... but ... I'm a quick learner and you'll see. Give me a chance. Two weeks and I'll show you." I did! I learned **so much!** Old people liked to go there and talk all day. I remember an old man from the Philippines who spoke a little Spanish; he explained certain words or expressions and I

would learn how to help customers. I made friends there, old people who brought me books to study or to read. I needed the money too, but I got more from learning the language.

At school they always put me in advanced levels. The placements were wrong. When I got there I felt frustrated. I remember once, I got to class and there was an empty chair so I said, "Is sitting here anybody?" A woman laughed and said "You don't say it like that. You say 'Is anybody sitting here?'" So, it was not constructive. I left and went back to school twice. Now I regret it because I still think I need **a lot more**. I needed basics in grammar, basics in speaking, basics in everything. I should have taken it step by step. If you jump you leave gaps. You can try to modify but it's hard to change.

After three months at the donut shop I felt ready to move on. I found a job looking after a 30 year old lady that had an accident and was brain damaged. She had a feeding tube. I was young and I wanted to put in practice what I had learned. I practiced many skills with her, such as the feeding care. That was something that helped me do the job I got in extended care after reaccreditation. Everything helped me get to where I am right now.

While I was there, I wanted to know what the nursing exam was like. I sent my papers to the nursing association who told me I was eligible to write the exam. I thought I'd try something easier first, so I went for the LPN (Licensed Practical Nurse) test. I bought a book and started reviewing. I couldn't finish. It was **so hard**! I still have the book and now it seems easy. Back then, I could understand maybe 40% of what was written because it looked like Spanish. I decided to give it a try anyway. I remember sitting at a long table, in a place like a stadium. They gave the instructions. I could catch some things, not everything. I knew I had to mark one of the answers in front of me, the best one. It was hard because it was part

cultural too. The way people think in North America is different from where I came from. A month later I received my score; I got 50% so I was pleased. My husband was also very happy; he was always pushing me so he said, "Now go to school, study, get the level of English you need and I'll work hard." But, I wanted to have a family too; I wanted to have somebody that belonged to me, was part of my life. We thought the States was not the right place for our kids. My brother who was living in Winnipeg sent us a letter inviting us, "Why don't you come here; it's nice. Canada helps." When we arrived in Winnipeg I was feeling the morning sickness; I was one month pregnant.

I wanted to do so many things. There were many opportunities to work and I knew that being legal I could get the job that I could not get in the States. But I was pregnant; my English was not really enough, so the chances were very limited. Also, Canadian standards are higher than in the States. Here you need to have a certificate for everything. I applied at two agencies, but they didn't call me back. I didn't have a certificate. I showed my credentials, my experience in the States and back home, but they still wanted the certificate. That was a year and a half after I left El Salvador.

I went to English classes. They put me in a fourth level. Oh! again! I was pregnant, feeling the baby kick inside me and I would go to the bathroom to cry, frustrated! I'm a person that always wants to be good at things, and there were people there that were better than me. I couldn't handle it. I felt stupid. I quit school again. The teacher's expectations were too high. She probably thought that I was stupid, that I couldn't understand, but she didn't know who I was, where I came from, how hard my life had been.

There was a father, a priest, who helped us. He mentioned a program to train

volunteer labour companions. The program prepared women from different countries to be in the delivery room with moms that could not speak English. With my little English and pregnant, I decided to do it. It was hard but in the end I passed. I worked for a year as a volunteer, being with the women, helping, translating, giving them emotional support. It was exciting for me. I was in a hospital! The place where I really wanted to be. It was also partly sad because I knew that I could do my job, even deliver babies; I knew what was going on but I couldn't communicate. That was hard but, if you see my story, I never stopped thinking that I had to get my nursing back! Never, never, ever. This was another step. I really enjoyed being a labour companion but then I had my daughter, my first daughter. I was crazy about her. I was breast feeding and I didn't want to leave her alone, not even five minutes, so I quit.

When my baby was maybe four, five months old, I went to one of those agencies that help immigrants. I talked to a Spanish-speaking counselor, she advised me to stay home and have all the kids I wanted. She said that once my kids were grown up, I could do something if I wanted to. She also told me it was impossible for me to become a nurse, as if it were a crazy idea. I could aspire to become a nurse's aide, she went on; I could be good at that. She encouraged me to get the certificate. I was so angry and upset with this person! Even though she spoke the same language I did, she was not helping me with my needs, with what I really wanted.

When my daughter was seven months old, I went to apply to Home Family Services. They had home support workers and care attendants. I went for an interview with the social worker. She really liked me and said she would hire me right away. A week later, she called me and left a message on the answering machine. The social worker managed a region, and

within that region, the supervisor for the smaller district where she was going to send me said that I didn't have Canadian experience so she didn't want to take me. I waited three days. I was ready to give up but then I got my strength back, called the social worker and said, "Listen, why are you playing with me. You tell me one day that I'm hired and the next day you say that I'm not hired. Why do you think I want this job? I can do more than that; this is just a step that I need. I'm just giving you my work for nothing." I was upset. She said, "It's not my fault. I want to hire you but if this coordinator does not want you I can't do much about it." Then I said, "She shouldn't say that I don't have experience because I do, and I gave you all my references as well" and I added, "Well, you know what, this is racism. People don't want to take me, and that is racism." I don't know where that came from. It came out! I was so upset. I thought why are these people telling me that I have no experience, don't they believe that I was working in El Salvador or is it that they don't care about my experience in my country, and they don't believe that nurses all over the world do the same things! Then she said, "Violeta, wait. I'll get back to you. Give me a couple of days." Not even a couple of days, the next day she called me, "Violeta, go to this address." Another coordinator took me. That coordinator gave me the best references I have ever had. She was so pleased with my work there.

My job was looking after a woman with Alzheimer, Dementia plus Paranoia... **Ahhh!!!.... God!!! very hard!!!** I worked there for a year, nine hours a day, being locked up with that lady inside, aggressive, having to deal with so many things. I got psychiatric plus geriatric experience.

My listening was improving, I had to communicate with the client, her son and with

my coordinator by phone. My listening also improved by watching TV. Finally, one day, suddenly, it was like my ears got unplugged and I could get it! I was amazed! I was so happy! I said, "Oh, I'm starting to understand!" It's strange, everybody learns differently, some people take one year and they learn. Maybe because of my lack of confidence, being scared, it took me longer.

I also improved my reading. Being locked up in that house with this lady, I read a lot. I read novels. I really got excited, "Oh, what's going to happen next!" I made use of my time, not only to earn money but to learn.

Finally, I got word from the nursing association, "OK we accept you, it's true, we believe you. You are a nurse in your country and you are capable of working here. The standards in El Salvador are equal to here. But there is one problem, the program you need, the Refresher Program for Immigrant Nurses, was canceled this month." I was sitting there in front of the coordinator of admissions; I just looked at her, "What did you say?" Yes, it had been canceled. I would have to work double or triple as hard! That would have been an easy step because the program was geared for immigrant nurses. That was in 1993. I didn't give up, I could do the refresher for Canadian nurses, but I knew I had to pass the TOEFL by myself. I knew I had to go to school and learn English. So I went to talk to a counselor from Unemployment Insurance. He didn't believe that I would do it; he said, "It's hard, it's almost impossible, maybe never." I wanted a course in English for Academic Purposes (EAP), he sent me to English for Science and Technology. There were engineers, agronomists, mechanics, doctors; I was the only nurse. It was oriented to science, computer science, so it was not the right English. I was supposed to have a high level of English but I didn't even

know what "did" meant. I was more frustrated than ever, but I stuck it out until I finished. I always knew that I had to start from the beginning. The language I had been using came from what I heard. I learned by repetition. In school, I learned the meaning of why this is "did" this is "don't" this is the "does" and how to put things together. I also learned a little writing, but it wasn't what I wanted.

I couldn't get into EAP because of the placement test. I did poorly in grammar and in writing. There was a four-level difference between those two and my reading and listening. I would have to wait another year to go into nursing. One more year, I had already been away from it four years. I talked with my counselor again, "I need the academic program, I need it. I have to finish." He said, "Well, no. you have to start. You have to do your high school first, and then you have to..." I didn't want to do high school; why did I have to go through that again. He never believed in me. He always said I had to go for high school, and why didn't I do an easy job; why bother, nursing was impossible. He tried to erase everything, but it went in one ear and out the other. I was focused on getting my nursing and I would get it no matter what. That's what helped me to survive. I think people here were not prepared for immigrant professionals, for their needs. Where was the bridge, the right bridge, the path? I thought there must be a way. I was looking for the right program, but the right program had been canceled. I was lost. I was always phoning and talking and doing my own research. It seemed nobody else had done it. They had given up. I wanted to hear from those that had succeeded, like our family doctor, a Salvadoran. He had done his specialization as a neurologist in the States, was forced to leave El Salvador and came to Canada. Here, he worked as a nurse's aide while he had all his papers assessed. He went through everything. After he got to know

me and found out I was a nurse, he said, "Violeta, don't jump. Set yourself a goal: not too long, not too short, three, four years; something that you will feel comfortable with, because if you set it too short you will feel frustrated; if you set it too long you're going to get bored, you're going to give up. No matter what, no matter how many times you fall, get up. Once you are there you will enjoy it." He was enjoying his work. That type of encouragement was something that I never heard from government staff working with immigrants.

The same UI counselor offered me a university preparation course. It was interesting. We heard lectures on Economics, Sociology and Psychology. That part I really enjoyed. We also had EAP, but it was too high and I couldn't cope.

The UI counselor called me again. "Violeta, I have the right course for you," he said, "it's an ABE program that could get you into college right away". I said, "OK." I was ignorant, I didn't know what ABE was. I did an Adult Basic Education Grade 10; that's what he sent me to do. Once I was there, I realized what was going on but I don't regret having done it. I reviewed my Math, the Metric System, Biology; I knew in nursing I would need it. What I did mostly was English. Even though it was Grade 10, it was Canadian. English was pure grammar and I got a sense of what the language was all about. I remember learning about run-on sentences and punctuation, something so basic but very important to read and to separate ideas. I learned to write paragraphs, to get main ideas. There were tapes, books, modules with a lot of exercises. If you were not able to pass a particular topic, you were stuck there, the term was running and I could see the rest of the Canadians just doing it with their eyes closed. For me, it was very hard. Learning about subject, verbs, helping verbs, nouns and pronouns was new. I probably started communicating better because knowing

about the language, I could prevent mistakes.

The teacher was very good, very positive. She was serious, not trying to please; she treated everybody the same way. I saw a lot of interest in the others; that is something that motivated me too. I had to study hard at home. I did it and I did well. I was very pleased with that program.

At that point I was ready to repeat nursing. I wanted to do it so badly, that I didn't care if I had to go back to the beginning, but it would have been a waste of my four years in El Salvador. So, I went to the only community college offering the refresher program for Canadian nurses. I was feeling confident enough to go and say, "Listen, I want to do it." Before I would have been scared. They accepted me without an entrance exam. It was a self-study program, quite expensive. It had lots of books. When I started reading, I knew that I didn't know anything. I was lost in nursing. They were talking about the Roy Model; we didn't see models in El Salvador. They were talking about communication; it was not the communication that I was used to. I read, and then I had nobody to talk to. I needed classes with a teacher.

At the same time, I applied at a hospital that was hiring and I got in as a nurse's aide. I worked part time in that hospital for four, five months, then I decided to come out West and visit my brother for two weeks. I was tired. I was tired of everything. For the first time in five years I said, "I don't want to hear about nursing. Life is short and I have to enjoy it." I wanted to take a break for a year. When I got here I phoned my husband, "I'm not going back. Resign. This is so beautiful. I'm not going back."

I started investigating. I called the RNA. There they mentioned the refresher at the

college. I think they also mentioned the ISA program, or I saw it in the newspaper. I felt very positive about the people in the association, although I had to go through the evaluation of papers again, and here there were more legalities. The TOEFL was higher, from 500 to 550! Here I also had to do the TSE, that was not required in the other province.

I went to ISA. I put in my application. As for the refresher at the college, I said, "No. Again to a college, no, no!" I was scared at that point, scared of nursing because of the many years without practicing. The knowledge was there but I started having that feeling, "Oh, my God! I'm just forgetting things!" My husband came a month later and I said to him, "I want to work! I want to know really what a nurse does here in Canada. I want to know about the culture; I want to be full time." So we both applied at a hospital and they hired me. With my background I didn't need a certificate; I was lucky. My husband couldn't get a job because he had a certificate! His certificate from Manitoba was not valid here. He had to repeat the whole thing.

When I started working, I didn't know anything. All I knew was that those were beds and those were patients. The work that I had done before in acute care was different; I had been working only once or twice a week and that was not enough. Here I was in geriatric, extended care; it was heavy work! doing all the care for nine, ten patients, learning a routine.

The level of English of my co-workers was very high compared to mine; they spoke English perfectly. Even now that I finished the reaccreditation and work as a nurse, they don't understand "How come this stupid care aid like us, who didn't even speak English, is a nurse and now she's our boss!" There's a lot of competition and people don't want to help you. Winnipeg is a smaller place, a little friendlier. I just cried at home but I never stopped

believing that I could do it.

Some nurses make you feel like you're stupid. You just do hygiene care and that's it. I remember one instance with a nurse who gave me the orientation when I started as a care aide and now that I am nurse, she is my co-worker. She was giving a pill to a patient but the patient was not swallowing. I suggested to her in a soft way (being soft has not helped me at all), "Do you think if you crush the pill and mix it with some food or jam it would help?" She looked at me and said, "OK, **I** am the nurse. I'm the one who makes the decisions around here." "OK," I said and left the room. I learned to be quiet, to just observe.

There were other nurses that let me look and help. People would ask me, "Are you a nurse from home?" "No, no, no," I would say. It was my life, a part of me, of being Violeta, that I always wanted to keep for myself. It was painful to remember that I was a nurse and I was doing a job that I was not educated for. It was a good job, but I didn't care about the money. It was more about goals, about dreams. I just kept that pain to myself and thought "Oh, some day..."

Sometimes when we had emergencies, I couldn't help myself, like when a patient was with hypotension. I told the new RNs, "Did you check the blood glucose?" "Did you do this, did you do that? as a care aide, not being scared. They just looked at me wondering how I had those ideas. They went and got the equipment and did it. I couldn't help myself. I couldn't keep quiet. They probably had the knowledge but at that moment they didn't have the experience to act, to think quickly. I was a mature woman, 28, 29 years old at that time. I saw those young graduates and I said to myself, "Oh, my God! What has become of my life?"

After six months of working at the hospital, I was called from ISA to do the placement test and then the interview. I was accepted. ISA was a bridge that helped me continue. It helped direct my life to where I really wanted to go, the next step, the refresher.

That was the first time I was with other nurses. I was around professionals, and that made me feel good. Of course, we had to learn to live with different personalities, different emotional stresses in life that we had at that time but all of us had the same goal, to pass TOEFL and then write the exam, the CNATS. Everybody was helping each other. It was exciting to be part of it.

The nursing part at ISA was the most exiting because it was nursing. It was, however, a little confusing; some things were new, not the nursing knowledge about disease and symptoms, but the approach to the patient. Here the patient has the right to decide what he wants. Over there, nurses decide what's best for the patient. We did tests similar to the CNATS. I did quite well. The only thing I regret is that if we had a mistake we were never given the right answer, we never knew why. The thing I didn't know then, was that it would take me nine months of the college refresher program to understand why. I thought it could be done quicker, but to choose the right answer I had to know a different type of communication with the patient. We chose what we thought was best for us according to our culture but not according to this culture and then we started asking ourselves, **"Why?"** We were eager to know and to learn but the time was limited.

I learned how to do the TOEFL. I remember the first score I got was 537. I felt happy about it but I knew that I could do better than that. Doing TOEFL is actually not the hard part; the hard part is learning the grammar, the vocabulary, the reading, the main ideas, and

so on. TOEFL is just a test; it's a matter of learning how to do it properly, how to measure your time. TOEFL in the real sense doesn't help in nursing at all. I passed TOEFL and I still don't feel confident with my English.

The English part of the program helped in a way too, but I was overloaded by that time. I was working nights and going to school days. My husband was not working at that time; he was also going to school. I had a lot of responsibility on my shoulders, and then I got pregnant. Crazy me! I planned when to get pregnant and when the baby would be born so I could go to college. She was late! I was expecting to leave her when she was one month old but she was only two weeks. I couldn't even sit on a chair.

The second time I tried TOEFL, I had finished ISA already. I was six months pregnant, the baby was kicking when I was writing the test and I got 547. I missed it by **one** question! They were calling me from the college, I had put in my application and the manager said it would be OK for me to start even though I was pregnant, almost ready to have my baby. I was not eager to go. I knew that this was not a game; this was it! the end of the long trip. I was scared to get there because so many years had gone by.

By the time I started the program I was very excited. I was excited about the nursing program and about the English we had running at the same time. The English part, however, was not what I thought I needed. The teacher taught different points that I thought were not relevant. I was expecting a real TOEFL prep. and an assessment to see in what areas I was weak. We were not many students; I was expecting more one to one or at least an approach closer to what our needs were. I was frustrated thinking that I couldn't meet the English part of my needs and that I was wasting my time.

I think it was three or four months after starting that we did the first institutional TOEFL. It was a catastrophe! Instead of improving I got a very low score, 500 or 520. I think my attitude was the main problem. I was so negative. I was in class but I was not really there. I was angry that I could not use that time to study nursing. The next time I tried the TOEFL, I was scheduled to do an institutional one but I also registered to do it outside a week earlier. I felt quite good and positive I had got the score that I was looking for, so a week later when I wrote the institutional TOEFL, I was confident and relaxed. I got a very high score, I passed. A month later I got the score for the one outside the institution and I hadn't passed that one. It seems emotions can make a difference in your language and your thinking. After that I got out of the English program. I said "That's it. It's enough."

Not everything had been bad; there were good things in English, things that kept challenging us, for example, each of us had to prepare a topic on nursing and present a lecture to our classmates. That made us feel very good. We were discussing and talking about something that was really related to nursing; it was not just English.

By the time we finished the program, I felt quite confident with my reading but my writing still gives me problems. It's because I never went to school to learn from the beginning to the end. I went jumping into programs that didn't meet my needs. I've never been fond of writing, even in Spanish and so English was worse. I'm still scared of writing although I have improved so that now I can take a sheet of paper and start writing.

At the college, in English and in the nursing lab, they told us how to do nursing notes and records, but I think I learned mostly at work. For charting we use the passive voice: "Patient stated had a very poor night due to noise, due to pain." We were taught how the

nursing notes were done in the passive voice in the ISA course. Then at the refresher the ideas got more settled, and at work it got even better. When I started working, I was so scared; I would check other nursing notes to see how people expressed this and that. I took a little bit from everybody and that way I made my own format. Spelling is part of it; it's hard, but if I'm not sure, if I see somebody I know, I ask them. I have to ask somebody for whom English is not their first language, otherwise I feel that I leave myself open to criticism. Now that I've moved to acute care, I don't have a choice. I would say that 99% of the nurses that work in acute care and in surgical wards are Caucasian or nurses that have been born in Canada and have English as their first language. That's hard for me at work.

The English course met my needs in the sense of reaching the TOEFL score and freeing me from that barrier, but not the need for self-growth and to feel like I am a total professional. To be a professional in Canada or in any other country you need many things: you need the knowledge of that profession; you need to be able to express yourself, to communicate; you need to feel confident in your writing. One of my future plans is to take more English courses, probably in writing.

The emotional frustration that we were under was very hard for us. Maybe it's part of the personality of many nurses; we are always looking for the challenge of something new. That's something that the teacher probably didn't think about. English was not demanding and there were no high expectations; you worked at your own pace. Nursing, on the other hand, was very demanding. Every week we had two tests on Anatomy and Physiology. The answers had to be without any mistakes. If you changed an "e" for an "i" the whole answer would be marked wrong. One day I approached the manager crying, "This is unfair; I have

studied so hard. And because I make a mistake with a letter you give me this." I got 90%; I lost10% because I misspelled a medical term. I was going through post-partum depression, and I was pushing myself very hard, trying to learn as much as possible because I knew that if I got good scores in the program I'd have more chances to pass the CNATS than if I got only Cs. The manager said, "Violeta, in nursing you have to learn how to write; you have to say exactly what you mean; you can not make mistakes." I learned to survive and not to push myself too much.

The nursing reading helped a lot in upgrading my reading speed. Sometimes we had to do some pre-reading, read two chapters, and I had to fly reading, fly and not stop to look in the dictionary. What they have to do maybe is have a new course, call it Medical Terminology or English for Nursing, where they help us with the reading material that we have or they help us with the medical terminology. We should have more writing instead of being focused so much on self-study and self-reading.

We were pushing very hard in the program because we were mature; we knew what we wanted, and we didn't waste our time. The goal was right there and the focus was never lost. It was there all the time. I used to stay after class by myself in the classroom studying because I knew if I went home I had to start breast-feeding or cooking. I couldn't just go to my room, shut the door behind me, knowing that they were there outside. A week before the test I would go to the library and stay there until eight o'clock at night; I developed a migraine, developed everything, you name it! but the focus and the goal were there, always.

The practicum was wonderful; it helped me regain my confidence in my skills; it helped me feel that in nursing I'm not that much different from Canadian nurses. With the

practicum, I had to integrate my old knowledge with my present knowledge. I had to adjust all my ideas to the present for the good of the patient. I remember on my second day of practicum, I had to give an injection. I was forcing myself to feel confident "Oh my God, after so many years, six, seven years I haven't put an IM (intra-muscular) injection. I know I can do it. I have done it thousands of times." The patient was a young Caucasian. I think she was a college or university student. I was a student too, just starting. I needed the patient to trust me first of all, then, my instructor. Once I had that trust I knew my practicum would be easier. I knew my practicum instructor from before; she was the clinician where I had worked as a care aide. One day she had compared my English to that of her child; it was very stupid of her. She said "Oh, don't worry, I have my grade two kid, he makes the same mistakes." I felt my heart sink! In the practicum, when I was in the middle of the injection, my instructor wanted to stop me but I knew that I was doing it right so I didn't stop. After I finished she said, "What did you do? Did you remove the hands?" I said, "At lab we were taught to do it this way or that way. I chose the second." I gave her a good explanation so she said, "OK, Violeta, I think you did great, considering this was your first time."

After passing the CNAT and getting my license I continued working in the same extended care unit I had worked as a care aide. Now I'm working in acute care. Nurses coming from other countries are able to look after our growing older population; recent graduate nurses from here don't want to. In extended care you have to have the energy inside of you to deal with Dementia, psychiatric problems, aggression, and sometimes you have to deal with family issues. As a nurse coming from another country, you can tolerate everything. In acute care you are dealing with more life-threatening situations and you need

to have more advanced English. You need to express things immediately. That is challenging for me and that is why I'm in crisis all the time, crying. I know if I pass this step it will be great. I think I'm doing the right thing.

Every time I go to work I learn something new. The only thing that I hate is to have to call doctors. Some of them are beautiful; they are so patient; they listen to you; they come and say, "Can we talk about my patient? What can you tell me about him?" but others just ignore you; they are rude. Anyway, if I have to call a doctor, I have to think twice before I do it. I'm so nervous on the phone that I talk too fast and when I speak fast they have to say, "Say it again; what did you say?" I should learn to be more relaxed with myself, talk slowly and pronounce the words better.

I'm kind of shy when I express myself with doctors. I'm formal and that's kept a barrier between us. I try to smile, to be very professional, but people here are more relaxed. I really don't know how to be with doctors. I remember that in El Salvador, in Spanish, we would use more medical terminology than here. My co-workers here say to the doctor, "Oh, my patient is puking." I have asked them, "What is that?" They told me it's slang for emesis or vomiting, but they still use it. I work with a lot of young nurses, maybe that makes a difference. I try not to learn the slang; I don't think it's appropriate because if I get used to it, one day I'll say "Doctor, the patient was puking" and the doctor might be very formal.

There are doctors that have their own particular personality. One time I was talking to one people see as being rude. I said, "I want to tell you about the condition of a patient." He kept writing and ignored me, so I got tired and said, "Could you stop doing that and listen to me for a minute. What I'm telling you is important. It's about your patient. It's something that

concerns you." He just glanced over at me and said, "Do you mind writing it down?" "I don't mind" but since then he looks at me differently. I have the feeling that now he probably respects me a little bit more.

When you don't have your English as a first language your self-esteem is not so great. I get nervous when I receive orders by phone. I don't know the voice or the way they like to order; they just speak in their own language. They might say, "Give it a number 3 Q 4H PRA." That means, "Tylenol number three with codeine. Give it every four hours, when the patient requires it." I have to tell them, "Could you repeat it, please?" It makes me feel stupid. One day a doctor indicated 150 milligrams of Ranitidin. For IV it's 50 milligrams, the equivalent in pills comes in 150. I didn't really know the difference between injectable and oral, so when the doctor gave me the order over the phone I said to myself, "150, I don't think so. She meant 50." Pharmacy called me and said, "Could you tell me why it says here 50 orally?" and I said, "She wants one pill, one Ranitidin and Q 6 hours." He said, "Yeah, but it comes in 150." "Oh, sorry, I probably miswrote it, but it's 150." So, I realized that I wasn't sure if the doctor had told me one fifty or fifty, because she gave more orders. Sometimes I have to write down four, five different orders at a time.

When we call the doctor we also have to explain to them the condition of the patient and what we want. We know what we want, we want sedation for this patient, we want something to help relax their stomach after they vomit but to be able to obtain that medication we have to know how to give the right information by phone, how to persuade the doctor to give us what we want. Otherwise, I'm wasting my time calling him and nothing is being done for the patient; then the staff that's coming in the next shift would be stuck with

it. I'm still learning; I'm still working that out. I have to organize myself, my thoughts. I have to work on being more assertive. It's a language thing. I was assertive back home. I think I am assertive at home, with my friends, when I buy something but in nursing I still can't.

I also need to be more assertive with co-workers. If I give them all the help they ask for, I don't pay enough attention to my patients. I have to learn to say "No." I'm too soft at work. I feel confident about my nursing. I know that I know things because of my experience that they don't know but I see that they feel more comfortable in their environment. It's cultural. I am on a shift with four nurses, one unit clerk, one rehab and the patients. I'm the only ESL one. They tell jokes and I don't get them. I feel stupid! I just smile and say, "I don't know, I didn't understand." So, I just try to do my work with my patients and I don't socialize much, first of all, not to get into any issues that don't belong to me. Sometimes they are unprofessional and discuss issues about patients. I don't really like that. I don't know if it is cultural or if I am from an older era, if I was trained in a different way or if it's just me, my personality.

I'm too shy. I don't know, I think it's language. One day the clinician called me to the group, "Violeta, come and sit with us," and I said, "No, thanks." I took my coffee and I went to a room where we sit and watch TV. Then she asked me later on, "Why didn't you want to stay with us?" and I said, "There's nothing that I can talk with you guys about. I feel like..." and she said, "Well we were talking about where we all came from and..." Holland... all countries where everybody is Caucasian and I just felt stupid and I said to myself, "Violeta, why? You should push yourself." But I don't know how to make conversation. I talk to them; I present my own points but I don't feel comfortable. Maybe it's personal; it's me; and maybe

it's cultural, or sometimes it's the topic; I find them stupid; I can't see the point. It affects my feelings but not my performance. I have learned to separate my fear, or the things I don't like to do, from what I need to do for my patient. The patient comes always first.

So far I don't think I have any problems communicating with patients. But I can feel that I don't have the confidence of young Canadians who speak English as their first language. I believe it's because they hear my accent. I have to build their trust in me by explaining when they ask questions, by the quality of care that I provide, by the psycho-social, psychological and emotional support that I give to them after surgery, and by showing them that my skills are the same as anybody else's, that I'm a total professional. After that, I feel that they learn to trust but I don't think it will ever be a hundred percent like with the rest.

Sometimes I deal with professionals. I had a patient two days ago who just graduated as a nutritionist from UBC and was working in quality control of medication for a laboratory. This woman was well educated and knew what and why she was taking for medication. You have to know the kind of patient you have and how to approach them. You have to know what to say and you learn by listening, by your own professionalism. I think work teaches you how to express yourself with your patient.

I love nursing but acute care is not the area for me. I'm doing it to push myself, to challenge myself. The experience I'm getting is wonderful. My purpose is as always to improve my English. With my other work I didn't have enough chances to practice English because the elderly were mostly demented and couldn't hold a conversation. Secondly, I'm doing it to keep up my skills. I know it will open doors to other jobs. Thirdly, I'm looking to

get into community nursing; I love teaching; I believe in prevention and I think there's a Spanish community out there that would benefit from my help. I need my B.S.N. They could probably give me credit for two years of my nursing but I haven't started that yet because of the English.

I keep pushing myself, challenging myself. I don't want this country, this new culture to stop me from doing all that I could do if I were in my country. It's something inside of me that is pushing me all the time. I believe that life without goals is not life.

If I look back over the past six years, I feel great now; I feel complete, fulfilled with what I have done so far. Sometimes I wonder if I could have done it in a shorter period of time and why I didn't, but the reason why was the language; it was that I never was in the right place; it was because of the bureaucracy of the different English programs; it was because I couldn't find anything that was right. I could have learned by myself, but I was lazy, or I never had enough self-esteem or I was never confident in English so I thought English was something I couldn't get; it was too hard to reach.

If I compare myself with the nurse I could have been if I had stayed in El Salvador, I see myself as less experienced. Nurses there have been working all those years that I was trying to learn English, to integrate, to have my papers assessed. It took a long time. They just kept going. But something they don't have that I have is another culture. I have learned another culture, another way of thinking; another way of dealing with patients, more advanced technology.

My way of thinking is broader; it's more open. Something that helped me a lot through my training in nursing and to cope with the culture here is that when I came I was

not so old and I was really very eager to assimilate. I decided to forget about El Salvador and try to cope with the adjustment to this culture. It's something that wasn't hard; it just came easily because this culture is very soft. You have your rights; you can talk. You need to really adjust to the culture or let the culture come to you. You have to learn how things are and how to behave. That's maybe why I'm so soft and so shy, because I'm still learning and thinking. It's a mixture; I probably haven't been able to learn because of my speaking; I can not express myself a hundred percent. The funny thing is sometimes when I'm speaking to a doctor or co-worker and he's explaining something I say "¿Por qué?" when I mean, "Why?" Sometimes Spanish comes out and I don't notice. I'm scared to say something that is not appropriate so I prefer to be quiet and learn how things are and how to behave instead of being myself.

Chapter Five

Analysis and Discussion:

Process of Language and Culture Acquisition for Nurses Educated Abroad

In this chapter I will report and discuss the findings emerging from the life stories told by five nurses. This study was prompted by the question of how foreign educated nurses experience the process of seeking to work again in their profession, once they immigrate to Canada. I want to include a cautionary note to the reader, the findings I report in this section are based on the stories of five nurses. These were nurses who succeeded in obtaining reaccreditation; the stories of those who did not succeed are not included here, neither are those stories of the ones who obtain reaccreditation by other means. Within the group of five nurses, there are also individual variations. My concern is not to over-generalize and make assumptions for all NEAs based on the findings emerging from the five stories.

After reviewing the stories for themes related to this experience, I organized the emergent themes within the following three broad categories which correspond to the three questions outlined in the introduction to this study. The categories are as follows:

Nature of Nursing (How do foreign educated nurses perceive the mature of nursing in which they were socialized in their own country and in Canada)

a) Nursing as Innate Caring

b) Nursing as Culturally bound Approach

c) Nursing as Part of a Life-Career Path

The Process of Re-accreditation (How do foreign educated nurses get socialized into the culture of Canadian nursing through the reaccreditation process and programs designed to assist them)

a) The Basics - Beginning

b) The Bridge - ISA

c) Confidence - Refresher Program

The Present and Future of Working as a Nurse in Canada (What are foreign educated nurses' perceptions of language socialization after reaccreditation? How do they predict they will continue to be socialized into the profession of nursing in Canada?)

a) Working with Doctors

b) Working with Patients

c) Working with Co-workers

d) Working with Language

e) Choices around Work

f) Working with Identities

5.1 Nature of Nursing

In listening to the nurses' life stories, I was struck by what at first appeared to me to be a contradiction. A comment repeated by all the women in the study was that "nursing is nursing"; they spoke of nursing as something unchanging across language and culture; a profession that is the same in Canada as it is elsewhere. At other times, they pointed out that the Refresher program was key in preparing them to work as nurses here, implying that

nursing is something that needs to be learned, something that is dependent on language and culture. As I tried to understand this apparent contradiction, I realized that it was related to the nurses' perceptions about the nature of nursing. In this section I will examine themes related to the nature of nursing. I will begin with the aspect of nursing which nurses consider to be unchanging: caring, and then move on to aspects nurses view as being culturally bound, needing to be learned: the approach to patient and their relationship to doctors. I will also refer to their view of nursing as a vocation, a career-life path and how this path interacts with their personal life-path and other identities.

5.1.1 Nursing as Caring

The women in the study referred to caring as a quality underlying nursing, part of the fabric of nursing that supports or contains the identity of being a nurse. From the very beginning of their history as nurses, when they first became interested in the profession, the element of caring appears in their narratives and continues to reappear throughout their life stories. Both Nahid and Helen recall choosing nursing because of early experiences in hospitals where they were struck by the caring nature of nurses they saw for the first time. Violeta, on the other hand, was first interested in becoming a doctor; she recalls opening up dead animals she found in her backyard, while also pretending to take care of her father when he was taking a nap. Caring as well as inquiry were important for her as a child. Jane went against her parents' wishes to become a nurse because as she puts it, when she is taking care of patients from the heart, she is happy. Mary was inspired by Nightingale's "sweet heart and caring personality" when she read her story in junior high school. Caring is a basic quality of these women's forming identity as nurses.

The underlying nature of caring appears again further on in their narratives. In deciding to come to Canada, Nahid knew that she would be giving up a top position as head nurse of a children's hospital, nonetheless, as long as she could continue working as a nurse, even if she had to start from the bottom again, she would be satisfied since, according to her, she likes to take care of people. The desire to care for patients takes precedence over the desire for status. Jane, in recounting her experience in Libya, mentions caring along with responsibility and professionalism as being basic qualities that if present would allow a nurse to function well anywhere. Violeta does not talk about caring directly, rather, she mentions the ethics of patient care as being a fundamental guiding principle in her life as a professional. Ethics to Violeta has meant that she has turned down opportunities for work because she did not feel she could provide adequate care. It also meant quitting a job that could have provided good contacts and a faster route to nursing reaccreditation, because she did not agree with the way patients were treated there, the care, or lack of caring they received. She also mentions ethics in the context of treating patients as human beings when she disapproved of the way other health workers did not respect patient privacy and confidentiality. Mary echoes Violeta in saying that to her, ethics means that the patient comes first. Jane gives an example of her current employment where she was involved in a conflict with care aides who wanted to go on their breaks while she saw the need to care for the patient as superseding the need for breaks. In her eyes, the patient's care also comes first.

Finally, the essential quality of caring seems to be a something that is not learned, that is innate to nurses. Helen explains that basic nursing is taking care of the patient, being a caring person; it comes from the heart according to Mary and to Jane.

5.1.2 Nursing as Approach

A key to understanding the apparent contradiction between nursing as unchanging across cultures and nursing as something that needs to be learned in different cultures, appears in a statement made by Mary. She said that in Korea care of patients was a b□□□□ responsibility for nurses, while here, nurses also need to be aware of how they approach patients. Nurses define approach as the different ways of interacting with patients. The spontaneous 'caring from the heart' when put into practice has different manifestations in different cultures. What seemed natural and from the heart to nurses before, is something that they have had to learn here. One of the ways of caring that is different has to do with the power to decide what form this caring is going to take. Although nurses have the knowledge and expertise, it's the patient who decides if she wants the treatment or not. Nurses have to check with the patient for approval on specific treatments. They speak about the patient in Canada having the right to know what happens to his body and to decide what he wants done about it. Mary gives the example of a terminally ill cancer patient; while in her country, the patient was protected from the news of eminent death, here the patient is told, so that he or she can decide how to prepare for death. Helen gives the example of providing privacy for a gay couple in a long term care facility to express their sexuality.

Related to the choice of caring, is the expression of care. Patients should not be assured that 'everything is OK' according to Jane, because that may not be true. While before, Helen would have given advice to her patients, now she encourages them to express their feelings. Mary talks similarly about having shown sympathy, while now, through therapeutic communication she is learning to show empathy. Jane talks about learning to be supportive, to listen and also to allow for the expression of feelings. She illustrates this point

with the example she gives about how before, if a boy had hurt himself and cried, she would have told him to stop because boys don't cry, while now she has changed her point of view and feels that boys have as much right to cry as girls.

Nurses talk about the changes in where the locus of power is for deciding if caring is accepted or refused and how the caring is expressed, not as something that has been imposed on them or as something that they have been forced to accept, but rather as changes that make sense to them, as a way of offering the same type of caring that they would like to receive. Violeta believes that the new ways are easily accepted because Canadian culture is 'soft' and gentle. Jane talks about being willing to consider new things. Helen and Mary have even taken the new approach out of work and applied it home; they describe how they have tried using therapeutic communication with their family.

Most nurses believe that the approach to patients is culturally bound. They feel that nurses here would not have any problems, for example, in applying therapeutic communication since they were born here and are part of this culture. Violeta, the youngest of the nurses, believes that leaving her country soon after graduation, helped her assimilate faster, she was more willing to accept the new culture. While age and disposition were seen, in her case, as factors in learning the new approach, just being exposed to the new culture was not seen as sufficient to bring about changes in approach. Helen points out that these are skills that need to be learned formally in a program such as the Refresher program. In her opinion, no matter how long the nurse has been living in the new culture, she will not absorb the new ways of communicating with her patients.

5.1.2.1 Nurses and Doctors

In considering the nature of nursing, the nurses' relationship to the doctor is, like her relationship to the patient, bound by culture. The women in the study agreed that in their own countries, they were used to following doctors' orders, while here they are expected to question a doctor's orders if they believe the orders for medication are not correct. Helen explains that they have the knowledge and the experience to be able to do this and it is expected of them. In a sense, they have become the patient's advocate in representing their case to the doctor in order to get an order for medication or to check if the order is right. While in their countries they say they always had a doctor close at hand, here in Canada nursing requires more independence and responsibility. As Jane puts it, everything here rests on their shoulders. She illustrates the point with an example from her current job, expressing her frustration at trying to locate a doctor on the phone while one of her patients was going into cardiac arrest; "I need him now!!!" The nurses point out that they know what the patient needs but they can not act unless they have the doctor's order. Violeta talks about the challenge of explaining to the doctor the status of the patient in a way that will get her the action she is looking for, the order for treatment she believes the patient requires.

5.1.3 Nursing as a Life - Career Path

In listening to the life histories of the five women, I became aware of their sense of nursing as a vocation, nursing as being a career which follows a predetermined path. I will review in this section how nurses describe their career path, how they relate it to their personal life path, revealing other identities they have taken on aside from that of nurses.

In the case of these nurses, nursing appears to be a profession that is taken on for life. A sense of duty and responsibility to the vocation of nursing is one of the values that these nurses reveal in recounting their histories. Once they have taken on the profession of nursing, there appears to be a certain sense of being bound to continue in the field and provide a service. Mary, for example, in describing times when she stopped working as a nurse after getting married or while she was bringing up her son, sees the activities she was engaged as being trivial, even when she works part-time as an industrial nurse, it is not the same as working in the hospital. When a former instructor finds out she has not been working for several years, Mary feels that she is being disapproving of her because she has not been diligent. This sense of feeling remiss is present in her now that she has completed reaccreditation but has taken on a position as home support worker. It is as if she has betrayed her duty as a nurse even though the reasoning behind taking on the position was all in relation to nursing, to find out more about that aspect of caregiving, and to explore the field of community nursing. Violeta also shows a sense of career path in her history. She talks about how in the States she followed her husband's advice to not waste her education and work in the health field rather than take on something else like house-cleaning. She also punctuates her narrative with asides to the listener saying that all of this (her different jobs) will make sense in light of later events in her life. Her round-about route to nursing reaccreditation, passing through the States, working as personal carte attendant, working with Dementia patients, all contributed to her work as a nurse in Canada. Both Mary and Violeta, say that money and security are not as important as working in their field (Mary) or learning more and getting closer to the field of nursing (Violeta).

An important quality to the life-path of nursing for the five women seems to have been challenging themselves and striving to excel. Nahid and Helen took specializations after obtaining their degrees, which brought with them status. Nahid took two specializations, one in hemodialysis and the in pediatrics. Helen intends now to go back to school to specialize in the care of elderly. They speak about the specialization courses as something that they wanted to do because they wanted to know more about this area; as something that was a privilege accorded to top students; as something that brought them status. Their road in nursing has meant an increase in status and responsibility, advancing in the hierarchy of nursing in their own countries. Nahid, Helen, Mary and Jane, attained top positions in nursing. The sense of nursing as having a development as a career is further revealed when Helen, Mary and Jane talk about the type of nursing they are considering at this stage in their lives. Helen says that she is content working in extended care because as a mature woman, with aging parents of her own, she would like to work with the elderly to feel closer to her parents. Jane, Mary and Violeta ponder the higher challenge and status of acute care nursing over extended care or long term care nursing. Jane and Mary say that given their extensive previous experience, acute care or OR is not as important to them as to a younger nurse, although Mary is still curious about acute care and would like to test herself to see if she is up for the challenge. Violeta, on the other hand, has deliberately changed areas from extended care to acute care because as she puts it, she does not want this country to stop her from doing anything that she could have done in her own country.

Nursing as a professional career path and nursing as caring at times come into conflict. As the nurses progressed in their occupations and took on supervisory and administrative positions, these positions often took them away from the direct care of

patients. Mary put up with working in the instrument area because she knew that eventually she would be able to move on to a section where she could be in more direct contact with patients. Jane longs for the direct care of patients and laments the loss of practice in patient care, while at the same time describing the satisfaction she derives from being recognized by doctors as someone who is capable and merits the position.

As well as their identities as nurses, the five women reveal other identities such as wife, mother, practicing Christian, care aide. These other identities are engaged in an interplay with the identity of nurse, sometimes able to coexist and at other times entering in conflict with each other. All five nurses I interviewed are married and have children. Wife and mother appear in their histories as nurses as identities that demand some form of accommodation by their existing role of nurses. Their experiences vary from minor accommodations to more significant ones such as Mary's case, leading to abandoning nursing all together albeit not permanently. For Nahid and Helen, for example, getting married and having children determined where they would work. Nahid switched from work in a dialysis unit to work with children in her husband's clinic because he wanted her to work with him. Helen worked in an outpatient unit because the regular hours would allow her to look after her family. For Violeta, getting married had more significant consequences, it meant leaving her country to live abroad with her husband and abandoning her plans to study medicine. Mary's story is the one that shows most clearly how her identity as nurse is bound and contained by other identities. Being a wife meant for her stopping work as a nurse. She told in a crescendo tone of her efforts to convince her husband to allow her to continue working up until a few days before her wedding day when she finally gave up trying to sway him. After seven years of being away from the field, she managed to convince her husband to

let her back to do a short term replacement and eventually got a position as a school nurse, which in her words was the dream job for an older married nurse. It allowed her to continue with her multiple roles, nurse, wife and mother. Mary is now once again confronted with a conflict of identities. She took on a temporary position working as a home support worker. The regular hours allow her to take care of housework and attend to visiting relatives, while benefits such as a dental plan allow her to provide for her family. On the other hand, she is very much aware of the fact that she is doing work that is considered to be of much lower status than the nursing that for which she is qualified. In addition, her identity as a Christian is also in conflict with her identity as a nurse. Mary knows that if she wants to work as a nurse she will have to initially take work that is on-call and mostly on weekends. As well as not wanting to work Sundays because of religious reasons, she does not want to give up her work as Sunday School teacher. When I spoke to her, she stated that she was going to leave her position as home support worker, but she had not resolved the issue around working on Sundays.

Interestingly, Nahid, Helen and Jane speak of deciding to leave their country in the first person singular rather than as "we". They cite the need for a better future for their children as a reason for the decision. They knew that they would be leaving top positions in their field for an uncertain career future but the need to provide for their children was more important than their work life. Helen still talks about part time as being ideal for her since she needs to stay with the children at home while her husband is away.

5.2 The Process of Reaccreditation

In this section I will discuss how foreign educated nurses perceive the process of socialization into the culture of Canadian nursing through the reaccreditation process and programs designed to assist them. For some, it was part of a long round-about journey, for others it was more direct, for all it is a journey that continues after reaccreditation. The organization of this section follows the order of the journey, from their arrival, to the ISA program and finally the Refresher program.

5.2.1 The Basics - Beginnings

After leaving their countries and arriving in Canada (or the United States in Violeta's case) the nurses in this study embarked on the task of learning English and finding out what it would take for them to be able to work as nurses in their new country. In this section I will highlight some of the elements in the early part of their journey including language and nursing.

5.2.1.1 Language Beginnings

The nurses in this study differed in the level of language ability and relative competency in specific language skills when they began their journey of reaccreditation. All except for Jane had had some English in high school. Mary, Helen and Nahid mention taking English in university and having strengths in reading, writing and grammar. Jane and Violeta were stronger in aural skills, Jane through 'picking-up' some English in Libya while working in an international hospital, and Violeta through her work experience in the States. All the nurses needed to learn more English in order to both obtain the TOEFL and TSE scores

required by the RNA and to feel confident in working as nurses in and English-speaking environment. As Nahid explained, learning the language was the first step, even if she were able to pass the exam with the English she brought, she felt she also needed to be able to communicate in the workplace. The nurses sought to acquire English by taking courses and also by doing volunteer or paid work.

A common theme for the nurses in terms of learning English is that of barriers to adequate language training. These barriers included being placed in programs that were not appropriate, lack of appropriate free programs and long waiting lists for academic programs.

Nurses reported being placed in programs they felt were not appropriate. Helen, Nahid and Mary tell about their experiences with community ESL programs. Nahid says that the conversation classes in the adult learning centre were not useful; they were 'just conversation.' Mary was interested in conversation classes and found some that were free but were not as intensive or formal as she would have liked. Soon after Helen enrolled in school board classes, she noticed that most students did not have an academic background; they did not share her background or interests. Violeta's story of being placed in programs she felt were not appropriate for her is a long one and is somewhat different from the others'. Rather than feeling that the programs were not rigorous or formal enough, she felt that she was placed in programs that were too advanced. She speculates that, given her university education, assumptions were made about her language ability and, as a result, she was placed in courses that were above her ability. She was enrolled in and dropped out of at least five courses.

Jane was the only nurse who started her English education in Canada with the LINC program, since she had had no previous instruction in English. Mary commented that she and

her husband tried, unsuccessfully to take advantage of these free classes the government provides for new comers to Canada. Even though they pretended they didn't know very much English, they were not allowed to participate in LINC. She feels that the language cut-offs for LINC discriminate against immigrants like her. She feels that government should provide free classes for all new immigrants since, as well as receiving language instruction, the classes provide a general orientation to Canadian culture, institutions and government, which she and her husband missed.

Another type of free program which some nurses accessed was adult basic education classes designed for native speakers. Both Violeta and Mary enrolled in these programs and found them to be positive for different reasons. Violeta enjoyed being with other Canadian students and getting the support and stimulation that the mixture of cooperation and competitiveness of small group and individual self-paced program provided. Mary, on the other hand, found the small group, discussion activities with Canadian content of her Grade 10 class positive but felt that the individual work, self-paced Grade 11 class was not appropriate for ESL students like her who require more aural practice. Both Violeta and Mary also alluded to the fact that these classes were not really designed for immigrants like them. Violeta initially resented the fact that she was being sent to high school classes, being a university graduate, while Mary was frustrated by the fact that although the classes had a high percentage of ESL students, the programs were not always suited to their needs, since they were shared with students whose first language was English.

Experiences regarding language training also included barriers to existing paid academic programs. Most of the nurses reported having to wait six to eight months in order to start classes at Queen Victoria College (QVC), one of the city's largest institutions

offering a wide range of ESL classes starting with LINC and continuing with intermediate, advanced, college preparatory courses as well as advanced courses focusing on particular language skills, such as writing or pronunciation. All the participants had enrolled in courses offered by QVC at different stages of their reaccreditation process and plan to take more courses there in the future.

Nurses like Jane and Violeta, who required extensive language training and who could not afford to attend school full-time, combined going to school with periods of work. Violeta chose to work at times out of frustration from not finding classes at an adequate level. She decided to work in a dough-nut shop, for example, because she felt it would be the ideal place to improve her aural language skills. She recounts how in all of her jobs, she focused on practicing different nursing skills as well as communicating in English, from pointing to words in a dictionary, to later on reading novels or watching TV in English while looking after clients. However, she feels that by acquiring English in this manner, 'jumping' as she calls it, from program to program, from job to job, development of language competency suffered. She talks about the gap between receptive skills such as reading and expressive skills such as writing; as well as gaps in language accuracy which she has tried to cover with a great deal of difficulty.

Jane, on the other hand, tried to combine working full-time with going to school. She describes how it was impossible for her to concentrate on her studies after having worked all day. She suggests that since nursing requires a high level of English competency, given the legal implications of administering medications and the interaction required with patients, colleagues and doctors, NEAs, considering reaccreditation should study English first until they reach college level proficiency.

As well as learning English through programs and work, nurses sought learning opportunities through volunteer work or by studying on their own. Nahid tells of volunteering at a senior's daycare centre for a year to practice spoken English. She chose that setting in particular because she had heard that older people have the time and interest to talk to others. Both Nahid and Mary also studied on their own with books. Mary reports that it was difficult to keep motivated through self-study.

The paid and volunteer work experiences nurses sought provided not only opportunities to acquire and practice English but were also somewhat related to the nursing field.

5.2.1.2 Nursing Beginnings

Volunteer work and paid work in the health care field were part of the life stories of three of the nurses. When these experiences were first mentioned, I expected to hear that they had provided an initial glimpse into the culture of nursing. Surprisingly, although they had an impact on their determination to be reaccredited, the experiences did not provide them with a sense of what it was like to be a nurse in Canada.

Both Nahid and Violeta volunteered in fields related to health care. As mentioned in the previous section, Nahid volunteered in a senior's daycare centre, while Violeta volunteered in a hospital's delivery room as labour companion to Spanish-speaking women.

While Nahid remembers her experience as positive; Violeta has mixed reactions to her volunteer experience. Volunteering at the daycare centre for Nahid meant that as well as having an opportunity to practice English and develop friendships, she was in contact with other volunteers, retired nurses, who although not able to provide her with information as to

reaccreditation, were very supportive and encouraged her to pursue her nursing career in Canada. Eventually, through one of the seniors' daughter she found out about the ISA program. For Violeta, giving support to women in labour was a positive experience, on the other hand, her initial excitement and curiosity about being in a hospital, seeing special equipment and watching nurses work, was dampened by the fact that nurses did not have time to explain things to her or to the woman in labour. Violeta felt frustrated not being able to participate as a nurse in a procedure that she had handled many times before in her country.

Both Violeta and Jane worked as long term care aides in hospitals. Prior to working in a hospital, Violeta had also provided personal care to several clients in their homes while living in the United States and later on in Canada. Violeta speaks of this experience as being valuable in terms of providing her with knowledge that would be useful in her later work as a nurse in extended care. Jane also considers the information she gained in her Long Term Care course on Dementia and Alzheimer's valuable given that the demand for nurses in this field will increase in the near future. However, both women agree that working in a hospital as care aide did not give them a sense of what it would be like to work as a nurse. They said that both nurses and care aides were very busy and did their own work separate from each other. What this experience did was to underline for them the fact that the work of a care aide and that of a nurse are very different and that they definitely did not want to work as care aides. Their experience motivated them to seek reaccreditation. Jane talks about watching through the Operating Room windows, yearning to be inside, working as a nurse, as she had done for 30 years. Violeta describes the pain of being a nurse and doing a job of a lesser status. She said that some nurses made her feel stupid and that at times, even though she did

not want others to know that she was a nurse, she could not help herself and gave instructions to new nurses who were at a loss as to what to do in emergency situations. Jane recognizes that many nurses go into long term care aide work because they need the money and do not have the language to seek reaccreditation as nurses. According to her, they have no choice, however she insists that long term care is not nursing work and that once nurses start working it is very difficult for them to find the time and energy to study English, thus reducing their chances of getting back into their profession.

5.2.1.3 RNA Requirements and the Next Step

During this initial stage, nurses contacted the RNA and began the formalities of applying for reaccreditation. The nurses do not have anything special to say about the evaluation of documents other than the fact that the RNA accepted their credentials. Mary says that although she had to send away for her documents all over again because of a procedural matter, she was not resentful. There is a tone of sarcasm in Violeta's comment about the RNA deciding that they did believe her, that she was indeed a nurse and that nursing in her country was similar to nursing here. Helen on the other hand, expresses appreciation for the opportunity to have credentials assessed and a have a reaccreditation process in place unlike other professional careers.

It was through the RNA that the five nurses heard about the ISA program and the Refresher at the college. Information and knowledge of how institutions and bureaucratic systems work in Canada appears as another theme in the nurses' narratives. Having knowledge and correct information as to how to proceed in their journey of reaccreditation is very valuable for the nurses. Violeta, for example talks about always researching and

searching for the right program, phoning and talking to people, looking for someone who may have done it before but finding no one. Nahid talks about misunderstanding the type of program ISA was, realizing that it was not the refresher program too late, feeling stuck with something of very limited value to her. Mary gives an example of not being aware of institutional practices in this culture. She explains that when she went for an interview at ISA for the NEA program and the program coordinator suggested that she prepare for the TOEFL examination on her own given the high score she obtained in the entrance test, she accepted the comment and missed an opportunity to continue progressing towards her goal of reaccreditation. A year later, she applied once again and got accepted.

5.2.2 The Bridge - ISA

The ISA program for NEAs appears in the narratives of the nurses as a bridge connecting them to the Refresher program leading directly to completing reaccreditation. They talk about the program helping them organize themselves, directing their lives to where they really wanted to go. It was a place where they received information about the next step and where they shared information with fellow nurses as how to move faster.

Most nurses mention the fact that this was the first time they were in a program with other nurses and that it was a very positive experience. Being around professionals (Violeta) with similar backgrounds (Helen) made them feel good. Everybody was helping and encouraging each other (Jane, Helen, Violeta) because they had the same goal. In this section, I will discuss the two main elements in the program: language and nursing.

5.2.2.1 Language

The program's main focus was language development and TOEFL/TSE preparation, as well as a general introduction to nursing in Canada. In general, nurses were disappointed that in the nine months of the program they did not make as much progress as they expected in English. Only two in a group of 18 (Mary was one of them) got the required 550 score in TOEFL. Most of them went back to QVC courses after completing the ISA program and before starting the Refresher. Jane felt that the English course needed an instructor who was more forceful, someone who could provide more structure and guidance. She explains that nurses are used to a rigorous style in education and that a system where things are left up to the student is not the best one for NEAs.

The ISA program provided nurses with an opportunity to try the TOEFL test for the first time. They said they were able to learn about the test and how to write it. In general, though, nurses were skeptical about the validity of the TOEFL as an instrument to measure language competency for nurses. As Violeta put it, doing the TOEFL is not hard, what is hard is knowing the grammar, vocabulary and reading. Even though she passed the TOEFL, she is still not confident about her English language skills for nursing.

The TSE received even stronger criticism than the TOEFL. One of the points of contention was the change in the scoring system which took place while they were in the ISA program. With the new scoring system most nurses enrolled in the program were not able to obtain the required score either at ISA or at the Refresher, while in the past, most other NEAs had had no difficulty in achieving the desired score. Three of the five nurses had to request a special waiver from the RNA to be allowed to sit for the CNAT. They stated that although

their TSE score had not changed over the course of the two programs, they felt that their oral language skills did improve. They also cited their practicum supervisors as being surprised that they did not pass, since they felt that the nurses were able to communicate adequately on the job. Helen questions the fact that in the course of 20 minutes, a test could determine if a person was able to communicate at work. She said that the test required immediate response, something that would be difficult for even some native speakers to do.

5.2.2.2 Nursing

The nursing part of the program, was seen as either not very useful (Helen and Jane) or as the most exciting part of the program (Violeta). They all agreed that it was confusing. The confusion arose out of practice quizzes the instructor administered which were similar to questions on the CNAT. The quizzes had a high number of psycho-social questions requiring a knowledge of the Canadian culture of nursing. Nahid felt frustrated with the instructor who did not go through the answers to explain the cultural differences. She tells that the highest score would be 30%, that nurses felt put down and discouraged. For Jane, the source of confusion was lack of language. She feels that before nurses can consider issues in nursing they must have college-level English. Violeta also says that she did not know why she had chosen the wrong answer to questions that seemed to be correct from the perspective of her culture and experience. She says that at the time she did not realize that these questions could not get a quick explanation, that it would take her another nine months in the Refresher program to learn differences in communication and in culture. She says that in this part of the ISA program she started asking herself "Why?" but the answer was not to be found until later.

Other aspects of the program also received mixed reviews. While some felt that the series of guest speakers from different areas of nursing provided them with a good overview of the range within the profession, Nahid felt discouraged by the RNA delegation who suggested students sign up for various committees and did not follow up on the NEAs show of interest.

The visits to hospitals and care facilities was useful for Helen. In general, though nurses agreed that they needed to be more involved in a hospital to learn what it was like to be a nurse in Canada, the ISA program could not provide this for them. Volunteering as nurses in hospitals was not possible either. The only way they could get this opportunity was through the Refresher program. This was the next step they took.

5.2.3 Confidence - Refresher Program

The main themes emerging from this period in the reaccreditation journey are those of challenge and confidence. Nurses found the refresher program to be very rigorous and demanding; they also spoke of feeling confident at the end of the program that they were equipped to work as nurses in Canada. This feeling of confidence appears to be an indicator of their successful passage through their apprenticeship into the culture of Canadian nursing. I will begin this section with one component in the program that did not fit into the category of confidence builder and rigour, that is the English language classes. Secondly, I will report on the different components of the program that contributed to building the feeling of confidence the nurses speak of, including ways in which these components provided for language socialization. I will also report on the program's learning environment.

5.2.3.1 English Language Classes

Of all the components in the refresher program, nurses viewed the English classes as providing them with the least value. Language and communication is recognized by them as a very important aspect of being a competent nurse, however, the confidence they felt in being able to work in an English-speaking environment was, in their view, not acquired in the English classroom. The ESL classes in the nurses' narratives appear as being 'just' a preparation for TOEFL (Helen), as a kind of review of grammar (Jane) and, as presenting points that were not relevant to nursing (Violeta). According to the nurses, they did not have time for English because they were too busy studying for the other subjects. Jane points out that the instructor would assign a certain amount of pages to read and do exercises from a workbook; she adds that students had no time for ESL homework and therefore took turns copying the homework from each other because they had to study for their nursing tests.

Violeta recalls her frustration with the course; she felt she was wasting her time. The course was not what she had expected; she was hoping that closer attention would be paid to individual needs. While she felt she needed more writing, other nurses thought they needed to develop more oral skills. Nonetheless, Violeta also mentions some positive activities in the classroom; for example, a lecture students had to prepare and deliver on a topic from the area of nursing. This was seen as being useful because it was related to nursing.

All nurses reported that their TOEFL scores improved significantly in the course of the nine-month Refresher program, however, they believe that the improvement was due to the heavy load of readings for their content subjects rather than from the English course. Violeta explains that although her need to pass the TOEFL was met, the need to communicate as a professional were not met.

Nurses compare the learning environment of the English course with their other courses. While the nursing courses were very demanding, requiring extensive reading and preparing for two weekly tests, the English course was not challenging; students worked at their own pace. Jane says that, once again, they had such a nice lady for an ESL instructor, just like in the ISA program. In their stories, the women state and show that nurses like to challenge themselves, this course did not sit well with this part of their identity.

When asked if the course should have been more demanding, most nurses replied that the Refresher, in general, was already very demanding, and that it was hard for them to imagine how they could have coped with more work. Violeta suggests that perhaps the English course could be redesigned to assist students with the reading material and with medical terminology from the nursing courses.

5.2.3.2 Communications

Communications along with the practicum were the two elements which the nurses reported were most useful in preparing them to be competent nurses working in the Canadian setting. The women mention that the form of communication they learned was completely new to them. Given that they are in a different culture, they need a different way of communicating, they said. The nurses give many examples of situations that require a different response in this culture from the one they would have given previously. Mary mentions that even body language is different here than in her native Korea.

Therapeutic communication in which the nurse encourages the patient to express feelings, and assertive communication using "I" statements are the communication styles the nurses mention they had to practice first with classmates and then in the more realistic setting

of the practicum in a hospital. Helen describes the process of adopting the new style of communication: at first, repeating the new phrases felt strange to her during practice; later on, in the practicum, she saw some examples of assertive communication style put in practice and realized that they were effective. In fact, Helen, Mary and Jane report using the new style of communication at home with family members. Helen says she knows the way she should communicate at work, or at least the way she is expected to communicate, but that she needs to use it more to integrate it into her practice.

5.2.3.3 Nursing Review: Anatomy and Physiology and Nursing Skills

Anatomy and Physiology, according to the nurses, was a good review of knowledge they had acquired many years ago in university. The content was not too difficult, however, what they found demanding was the amount of content to be reviewed. They all remark that there was no time to read the many pages from their text in order to prepare for the two weekly tests. As already mentioned, the nurses feel that the readings in this course helped them to increase their reading speed.

Nursing Skills, according to the participants was not a difficult part of the program either. Although they did learn to use new techniques and to work with new equipment, their previous experience seems to have given them a base from which learning different methods was easier than if they had had no previous practical training.

5.2.3.4 The Practicum

The practicum or clinical is one of the key elements in the journey of reaccreditation for the nurses. The theme emerging from this stage is confidence. Nurses said that the clinical prepared them to work as a nurse in Canada.

The practicum provided them with an opportunity to integrate old knowledge with current knowledge; to apply the theory they had learned in the classroom; to work with new equipment and to learn the culture of hospitals in Canada first-hand. As a result, the nurses felt confident in their abilities. Helen, for example, says that she was reassured that she was doing well and that nursing was still the type of work she wanted to do. Violeta also says that the practicum was a wonderful experience which helped her feel that in nursing, she was not that different form Canadian nurses.

Some of the nurses also make specific mention of feeling confident in their language abilities during the practicum. Mary was relieved that patients understood her pronunciation, while Helen feels that with the amount of language she has she will be able to communicate adequately with patients. On completing the Refresher, not only were they confident in their nursing skills, but also in their ability to communicate. Later on, as they started to work, nurses identified further language needs.

5.2.3.5 A Place to Learn the Culture of Nursing

Only one of the five nurses in the study was required to take the refresher program, since she had been away from nursing for more than five years. The rest of the nurses took the program by choice. They could have, instead, prepared to write the CNAT on their own

or with the assistance of a tutor. As I listened to the nurses give their explanation of why they had chosen to spend nine months in this program, I heard the same theme repeated from all five: they needed a place to learn the culture of nursing in Canada. This was knowledge that was not theoretical, and could not be obtained by studying on their own, from books. Helen says that just writing the exam and passing was not enough; she had to learn the way she was expected to work here. Without the Refresher she would have had no idea of what nurses do here. The Refresher was a place where she could learn how and what to communicate, that is, the culture and language of nursing. Nahid explains that she took the Refresher because it was really important for her to learn more about nursing in Canada. As well as familiarizing herself with the exam questions she was able to be in a hospital to see what went on there, to familiarize herself with the equipment and the way of treating people. Jane says she can not imagine how foreign educated nurses function without the Refresher it. She says the program gave her everything she needed to be confident.

5.2.3.6 Learning Environment

The program, as well as being a place where nurses could learn about the culture of nursing, was significant in the learning environment it provided. The intensity and rigorous style of the program, matched the aspect in nurses' identity that seeks to be challenged. As already mentioned, the nurses remark on how intense and demanding the program was. They describe how their family and social lives were disrupted during the nine months of the program; but they also talk about how hard they pushed themselves, because as Violeta states, they knew what they wanted. Helen adds that at the end they felt proud of themselves, of having stuck with the program and been successful.

5.3 Working Nurses' Present and Future

The life stories of the five nurses I interviewed do not have an ending. They completed the process of reaccreditation which qualified them to work as nurses in Canada. They passed the institutional marker determining acceptance into their profession and they passed the personal marker of feeling confident that they would be able to work as professionals in their new setting. However, the process of socialization into the profession of nursing is on-going. As Violeta says, she learns something new every time she goes to work. In this section, I will briefly explore how nurses view their present process of socialization in relation to their communication with doctors, patients and co-workers; what they see as future options for language learning, choices around present and future employment in the field of nursing, and how they view their changing identities as nurses.

5.3.1 Working with Doctors

When nurses talk about their current work, one of the biggest challenges they face is communication with doctors. The challenge seems to stem, in part, from the different roles nurses and doctors play in Canada, which I described in the first section of this chapter. Unlike in their countries where nurses working in hospitals have doctors working side-by-side with them, here nurses need to communicate with doctors over the phone regarding orders and the condition of patients.

In general, nurses do not like receiving orders over the phone because they are afraid they will not understand and will make a mistake. Both Violeta and Jane give examples of either catching mistakes they made in taking down orders or having to call the doctor back to

double-check the order. This is particularly the case for Violeta who works in acute care where she's had to get used to the special way doctors give orders using an abbreviated code-like style at a very fast rate, and having to take down two or three orders at the same time. Jane, who works in extended care, does not like the telephone as a medium of communication with doctors, in general, she prefers face-to-face communication. Helen, on the other hand, says that she does not mind having to call up doctors.

The other aspect of working with doctors is being able to communicate to them the condition of patients. Violeta explains that as nurses they know what the patient requires; the challenge is to present information about the patient in such a way as to get the doctor to write the order. This requires, first of all, being assertive in getting the doctor to hear the nurse's report. Violeta recalls an encounter with a doctor who she felt was ignoring her, and telling him to stop and pay attention to what she was saying. She says that after that episode, the doctor seems to have more respect for her. Jane tells about trying to get a hold of a doctor on the phone regarding an emergency situation and having to call back and demand to talk to him right then and there instead of being told that they would pass the message on to him. Being an advocate for the patient also means being organized and confident to present the information in an effective manner. According to Violeta, she needs to get used to this and get more practice.

In general, nurses talk about having more responsibility rest on their shoulders here, while in their countries they had a doctor always next to them with whom they could consult.

5.3.2 Working with Patients

The nurses' view on communicating with patients seems to differ according to the setting. For Jane and Helen, there are no difficulties in communicating with patients. They work with elderly patients and find that they can communicate well, that patients are eager to talk to them, and that they do not mind their accent. Jane, however mentions that she would like to be able to communicate better with the relatives of patients. She feels that her language ability falls short when it comes to being able to express herself with the complexities that she would like to in talking to the families of the residents.

Interestingly, although Nahid works with a similar population in terms of age, she has had to face difficulties in communication because the residents are Chinese-speaking. She has had to work with translators and tells of feeling frustrated because she could not offer care as a result of the language and cultural barrier. She says that after two years of experience she can finally feel that she understands her patients better and can tell what they want.

Working with patients in acute care appears to be different; there is not the opportunity to get to know the patients over time. For Violeta, the key is to establish trust with the patient, by showing a professional manner, by showing she is knowledgeable, and by offering emotional support. She needs to assess the type of patient she has and adjust her communication to the patient. She gives examples of how she would adjust her communication depending on whether the patient was a university graduate, someone with little formal education, someone who has English as a Second Language or an elderly patient. Violeta feels, however that no matter how hard she tries, she will never be able to gain the

full trust of patients because of her accent. She will always be seen as being different from other nurses.

5.3.3 Working with Co-workers

The themes that emerge in relation to co-workers are feeling out of place because of different cultural norms and clashing over different cultural values.

Interaction with colleagues at work involves socializing, greetings, small talk on at the nursing station or during coffee breaks. The nurses talk about feeling uncomfortable or out of place in these settings. Nahid gives and example of different customs in greetings and how initially when a colleague did not greet her she thought she was being ignored because she was foreign. Violeta talks about feeling different from her colleagues, using a more formal level of language with doctors than other nurses, not wanting to join colleagues for coffee because she can not imagine what common interests they might have; feeling different because she is the only non-Caucasian on that floor.

In extended care, nurses work with and supervise nurse's aides. As in the case of Jane, Mary and Nahid, the nurse may have held supervisory positions as nurses in their country of origin, but here she needs to contend with different values and communication styles. Jane gives an example of some difficulties she encountered with care aides, identifying the source of the difficulties as being culturally bound values. For her, the care of the patient comes first, while for the aides, their right to their breaks was a priority according to her.

5.3.4 Working with Language

In general, nurses feel they would like to improve their command of English. Other than wanting to express themselves better at work, nurses differ in terms of what they see as their priority. While Jane and Violeta want to focus on written English, others like Mary are concerned about their spoken English. Most of them intend to enroll in college classes. Jane, for example, says that if she tried to study on her own she would procrastinate. At the time of the interviews they had not registered for any courses; they were waiting to get more settled in their new routines.

Helen was the only nurse who felt that she would be able to build on her knowledge of English through work. She says that she has a sufficient base knowledge of the language to allow her to learn by working and by communicating.

5.3.5 Choices around Work

All five nurses upon receiving their license began their careers in Canada working with the elderly population (Mary, although working in home support rather than nursing, is also working with an elderly client). Violeta switched settings and is currently working in acute care. In the future, three of the nurses (Helen, Nahid and Jane) want to remain in the area of extended care; while the remaining two would like to work in the field of community nursing. The place where nurses work appears to be in part not a matter of choice but determined by the fact that they are non-native speaking immigrants and in part due to choices they have made. The choices seem to be governed in part by some of the values mentioned in the first section of this chapter under the nature of nursing. These points

include, challenge, caring and service to the community, other roles or identities, and a sense of career path.

One of the factors determining the choice of working in extended care appears to be the perception that extended care requires less competency in English than emergency or acute care. Nurses say or have heard other nurses say that work in acute care requires quick response and a very good command of English. Violeta states that one of the reasons why she switched from extended care to acute care was that in the former, she did not have many chances to practice English, since many of the patients suffered from Dementia and Alzheimer's. Another factor in determining the choice might be that extended care is more demanding from an emotional point of view and is perceived as being less attractive than acute care. Nurses say that recent graduates who are native speakers would not want to take extended care positions so they go to the NEAs. Violeta believes that NEAs' life experiences have prepared them to endure anything and therefore they are more willing to take on the less desirable long term and extended care work.

As already mentioned in the section under Nature of Nursing, one of the factors determining choice of workplace has to do with the nurses' other identities, in particular those related to family. Helen, for example, is working part time because she needs to take care of her children while her husband is away. Nurses also mention making choices because of their stage in life or career. Helen says she prefers extended care because she misses her aging parents and by working with elderly patients she feels she is somehow closer to her parents. Jane and other nurses report that since they have already had a varied experience they feel comfortable staying in the less challenging field of extended care. Violeta, on the other hand, who has not had such an extensive experience says that she is pushing herself to

work in acute care because she wants to explore her career potential. She is responding to the element of challenge. Mary in considering which route to take is also tempted by it. Finally, the principle of caring and of service to a community is also present in the nurses' choices. Violeta and Mary want to go back to school to obtain a B.S.N. in order to work as community nurses because they have seen the need for nurses working with their ethnic communities. Mary stayed with home support because she wanted to organize a forum within her community to inform them of the service provided by home support workers.

5.3.6 Working with Identities

In reflecting on their identities as nurses before coming to Canada and their identities as nurses now, the nurses' narratives tend to become ambivalent, qualified and hesitant. Words such as 'uncertain', 'not sure', 'don't know', 'I hope', 'haven't thought about it' are part of the introduction to their statements. Their descriptions of who they are now include the same themes of permanence and change discussed at the beginning of this chapter, dealing with the perception of the nature of nursing. Their accounts follow a similar pattern, they start by saying "I am the same" followed by "but..." and a statement including elements of language and culture. Mary says she has not changed but she has more knowledge. Helen says that the difference is between the two cultures; the difference is language and culture, but that as a nurse it is the same working with patients, the difference is just language. Nahid says that she is not that different, only more experienced, that she speaks English better; she says that the difference is in culture but nursing is the same. Their statements are remarkably similar among the three and parallel their views on nursing as

caring, something that is the same everywhere while nursing as approach is something that must be learned.

Jane's description, although not following the exact pattern as outlined above also acknowledges her old and her new self, focusing more on what she has learned and how she has changed. She talks about bringing her experience as nurse to Canada and building on it by learning something new.

Violeta gives a more extended description of what this stage of identity formation feels like for her. She begins by saying that she feels complete and fulfilled having finished the process of reaccreditation. Although she has less experience than her Salvadoran fellow graduate nurses because of the six years it took her to obtain her license in Canada, she feels she has gained in having another culture, a broader way of thinking as well as in learning new technology. The process of acquiring the culture seems to her to be a mixture of culture and language, letting the culture in and at times not being able to learn the culture because of the language barrier. It also appears to be a mixture in terms of how much she feels this new culture to be part of herself. She talks about being scared to say something inappropriate, preferring to be quiet and observe rather than being herself. She gives as an example the times she inadvertently responds to a doctor in Spanish, implying that Spanish is 'her-self'. Violeta's story has many other examples of being in the border between cultures, as when she tells of not feeling comfortable with the degree of informality in her colleagues' speech but also feeling different because of it or; when she wonders if not feeling comfortable in socializing with the nurses on her shift is a question of age, race, language, interest, culture or personality. The sense of identity, of culture and language appear to be in a state of dynamic change for Violeta as well as for the other four nurses.

Chapter Six

Summary and Implications

6.1 Summary

In this section I will summarize the findings from the study and relate them to the existing body of knowledge as outlined in the earlier review of the literature. I will begin with some general comments and move on to three specific areas: identity, language socialization and immigrants and work.

This study attempted to gain some understanding, through the life stories of five nurses, about the process by which nurses educated abroad acquire the language and culture of nursing in Canada. The intent was to gain an insider's view on the process of transformation of these nurses' identities as they were socialized into a new language and culture. The stories tell of success in getting reestablished in the nursing profession. The nurses that did not succeed are not included; their stories also need to be told. What I have learned from the five nurses in this study is that they perceive the process of reaccreditation, as having been a positive experience; they have gained another language as well as another culture.

The five life stories meet at two points, in two programs designed to assist NEAs in the process of reaccreditation. While they share this experience, the paths they took in getting there vary. For some, reaccreditation took no more than two years; for others, the journey was longer and much more arduous. As well, while the stories share common themes of values and norms related to the nurses' identities and similar perceptions on the process of reaccreditation; they also present the individuality of each nurse.

The stories reveal a complex and dynamic process of what forms the nurses' changing identity. In order to provide a framework to review some of the complexity inherent in the identity of the nurses, I find Norton's (1997) model of looking at identity in its relationship to power as one which sits well with the five life stories. First, the nurses' sense of identity is related to their desire (West, 1992) to be nurses in the new Canadian context; the nurses answer the question "what can I do?" not, "who am I?" Secondly, their sense of identity is linked to symbolic power (Bordieu, 1977). Language and communication are exercised within a context of unequal relationships of power for the nurses, the power to "impose reception" on doctors, the power to be seen as competent by their patients despite their accent; the power to feel they can be themselves with their colleagues. Thirdly, the nurses' motivation to learn the target language can be seen in terms of an investment in their social identity as nurses. Their history of being professionals and of nurses along with their desire to continue as nurses provides them with the motivation to learn a new language and culture. The fourth concept of identity, that of subjectivity, appears in the nurses' shifting sense of self, which changes over time and takes on different subject positions depending on the setting. Thus, nurses' sense of identity shifts whether they are nurses in Canada or abroad, nurses in extended care or in acute care, nurses relating to patients or to doctors, nurses at work or wives and mothers at home; nurses in jobs which Canadian-born nurses find less desirable, or nurses taking on jobs which challenge the role they have been assigned by a society that discriminates against immigrants on the basis of language or colour (Bolaria, 1992; Li, 1992; McDade, 1988; Sauve, 1990). Finally, the notion that identity and power are collaborative rather than coercive processes (Cummins, 1996) can be seen in the

nurses' account of how they co-construct their identities with doctors and patients. Power and identity are mutually generated in these interpersonal relations.

As nurses are socialized into their new culture, the complexity of shifting and changing multiple identities appears to be contained or underlaid by values that seem to remain relatively unchanged. Caring emerged as a core, constant theme in the nurses' sense of self. This value characterizes for them nursing as nursing no matter where it is practiced. The outward expression of caring, which in their own country was largely an unconscious act, in Canada has become something to be practiced in a different language and culture; it has become a conscious act. The nurses had to learn a new nursing approach.

Another important element for the identities of these nurses appears to be the element of challenge. Throughout their careers, the five women tell of pushing themselves to achieve their goals through a variety of means: taking additional courses to get into a specialized field, or accepting extra work and responsibility in order to do administrative and supervisory work, or completing a demanding nursing refresher program to be licensed to practice in Canada, or taking on difficult, stressful assignments at work to test how far they can go in their careers in Canada, or making plans for further university education in order to serve their communities.

The accounts by the five nurses appear to indicate that programs that address the core elements of nurses' identities as well as their shifting sense of self are perceived by nurses as being more valuable than those which do not. Thus, the Communications course and the practicum in the Refresher program which facilitated the nurses' expression of care in their new setting were seen as very valuable. The rigour and intensity of the nursing side of the Refresher was also seen as positive while ESL classes were not viewed as favourably

because they were less rigorous, and they lacked the structure and testing present in the nursing courses.

In terms of language, the stories illustrate how the process of reaccreditation involves socialization into a new culture and language. The five accounts reveal how the meanings and functions of the language they use in patient care, such as expressing empathy, are culturally embedded, and how the values, morals and structures of knowledge are learned through the language (Ochs, 1988). The Communications course and subsequent clinical practice or practicum are good examples of places where legitimate peripheral participation (Lave & Wenger, 19991) appear to have taken place; the five nurses, as newcomers to nursing in Canada, became part of a community of practice. Furthermore, Violeta in describing the process by which she learned charting illustrates the process of scaffolding (Bruner, 1983). She explains that in the ISA language class they learned that the passive voice was used in charting and practiced how to form the passive voice. Later, in the Refresher Program's nursing course they learned more on charting. In the practicum they got to put their theoretical knowledge into practice under the supervision of the clinical instructor. Once she started working, she checked other nurses' charts and adapted them to create her own style, checking with peers whenever she needed extra help. This final step supports findings by Donato (1994) of instances of scaffolding among peers.

In this complex process of language socialization, programs which took into account and facilitated language and cultural socialization were perceived by nurses as being helpful, while steps in reaccreditation and elements of programs which did not take into account the context of nursing were perceived as not being beneficial. Thus, the nurses viewed Communications and the practicum as key elements in becoming confident nurses ready to

work in Canada. On the other hand, the TOEFL and TSE requirements, and by extension, the ESL classes focusing on preparing for these tests, were seen as lacking relevance to the reality of nursing practice. The elements in ESL courses that were contextualized and connected to the new culture at large or the specific culture of nursing were viewed positively.

Another theme from the literature which recurred in this study is that of collaboration between the fields of ESL and Nursing pedagogy. The notion of the ESL instructor's philosophy as being "caring/sharing" while the content instructor is more focused on external accountability and professional standards (Platt, 1993) appears to be born out by the nurses' accounts of the difference between the ESL and the nursing courses in the Refresher Program. Theyalso stated that ESL instruction focused on sentence level and formal aspects of the language rather than on the more complex discourse level and language for communication in nursing.

As for the area of immigrants and work, it is important to note that this study focused on cases of success. The cases of nurses who did not succeed in gaining reaccreditation are missing from this study and therefore the account of barriers like the ones appearing in the literature for immigrant professionals is also missing. Some of the women pointed out that there is currently a shortage of nurses; based on previous studies on supply and demand of labour (Bolaria, 1992; Butterwick & Ndunda, 1996; Li, 1992) one may speculate to what extent the RNAs relatively clear-cut policy on reaccreditation and the five NEAs' success may be influenced by broader socio-economic issues. The barriers and human costs which were reported by the NEAs and which support findings in the literature include: the TOEFL and TSE examinations as not being appropriate measures of language proficiencies required

by nurses (Cumming, 1989) and a case of "family investment strategy hypotheses" (Beach & Worswick, 1993; Baker and Benjamin, 1994) in Jane who postponed her education so her husband could pursue his first. Examples of human costs include Violeta's account of how she needs to put in the extra effort to gain her patients' trust because of her accent (Tomic & Trumper, 1992) and the nurses' accounts of how NEAs usually accept assignments considered as having lower status within the nursing profession such as long-term care, supporting findings regarding employment disparity between immigrant professionals and their Canadian counterparts (McDade, 1988)

6.2 Implications

The implications from this study fall within several areas including implications for other nurses educated abroad, for policy and practice, and for further research. First, future RNs seeking reaccreditation may benefit from reading the stories of those who went before them. The nurses' accounts may provided them with a better understanding of the process involved in preparing to work in Canada. Like Violeta, they may feel alone in their search for a way to be reaccredited. The nurses in this study remarked on the value of being in the company of other NEAs, to share information and a sense of working towards the same goal. Their stories may be another vehicle to offer encouragement to more nurses.

The implications for policy and practice are echoed in recommendations that have been made before by other studies (Abella, 1984; Cumming, 1989) regarding access to adequate training programs and services to immigrants, specifically to women and to professionals. There is a need to provide funding for language classes beyond the LINC level which would provide academic language training up to a college preparatory level in order to

allow immigrants with professional backgrounds, including nurses to contribute their previous education and experience to Canadian society. There is a further need for more programs which combine occupation-specific language training with opportunities for guided, work experience specific to the profession.

NEAs are fortunate in that their regulatory association has a clearly outlined procedure to follow for those seeking to work in Canada. Evaluation of documents, standardized testing for professional qualifications and information on programs to support professionals in the process appear to be positive features which other associations of professionals could adopt. One aspect of reaccreditation that needs to be re-examined is language requirements. Instruments used in assessing language proficiency should be reviewed to determine if there are more suitable alternatives to the current practice of using TOEFL and TSE scores as a means to measure the candidate's ability to communicate adequately on the job.

In terms of program planning and teaching, people involved in developing and delivering programs for NEAs should be sensitive to issues of identity and language socialization. Lack of sensitivity to Violeta's history and needs, for example, was one factor which contributed to her abandoning five language programs and being dissatisfied with two others. The nurses did not give priority to their ESL classes in part because the style of delivery did not match their sense of rigour and structure and in part because the tasks in class were often decontextualized. There also appears to be a need for more collaboration between the fields of nursing and ESL: how can Nursing instructors benefit from the language instructor's expertise in matters of how to teach students with limited language proficiency, facilitating the learning of content and at the same time the development of

language. Finally there needs to be closer attention paid to the ESL component of programs for NEAs: In what ways can the ESL class support NEAs with the academic skills they require for nursing courses such as reading and note-taking? How can the ESL course assist students in learning the language they will need to be competent nurses in the workplace? (the language of caring for patients, assertiveness with doctors and co-workers, socializing with co-workers, communicating with family members, charting, writing reports)

This study invites further research in several areas. An ethnographic approach including on-site observations and interviews in the classroom and in the hospital during the clinical would enrich our understanding of the process of reaccreditation. Questions for further study could include the following: How can ESL classes better support NEAs in meeting their language needs for reaccreditation and in preparation for work? How can language and content be better integrated in programs preparing nurses to work in a new language and a new culture? How can the disciplines of ESL and Nursing support each other in delivering programs for nurses? What is the experience of nurses who did not complete reaccreditation? Which factors contributed to incompletion? How have other reaccredited NEAs who did not access support programs such as the Refresher program complete accreditation? And how does their sense of identity differ from the nurses in this study? How does the process of language socialization continue over time, once reaccreditation is completed? What support mechanisms could assist NEAs in the workplace?

6.3 Reflections

I began this study as former coordinator of a program designed to assist nurses in their process of reaccreditation. I was in the role of being the expert, the guide. I conclude

this study as someone who has been guided by her students and has learned from them. Their articulate and reflective accounts of the process of reaccreditation, has made me wonder what I could have done differently. I am grateful for the opportunity they gave me to learn about them and about myself.

I thank Jane, Helen, Mary, Nahid and Violeta for the generosity they have shown in sharing of themselves and their time. The determination, persistence and strength shown by the women have been a source of inspiration for me throughout this study. I have been struck by the sense of professional ethics, poise and dedication they have brought to their studies and work.

At the end of our first set of interviews, Violeta played for me a song about changes, she thought I might like to hear. This song, composed by a Chilean exile (Julio Numhauser) and interpreted by Mercedes Sosa (from Argentina, my native country) was already well-known and loved by me. As I listened to it in Violeta's living room it took on a new significance. The song would come back to me as I heard nurses talk about how the changes they have experienced in coming to Canada have put them in a privileged position, straddling two languages and two cultures in a multicultural society, with the potential of being able to serve the health needs of their communities and therefore provide a very important service for their new country, Canada. I conclude this work with the final verses of the song and my wishes that the vision these nurses have for their future work will come true:

Cambia lo superficial,	Changes happen on the surface;
Cambia también lo profundo;	Changes happen also deep down.
Cambia el modo de pensar;	Changes happen to our ways of thinking;
Cambia todo en este mundo.	Changes happen to everything in this world.
Pero no cambia mi amor,	But no matter how far away I may be,
Por más lejos que me encuentre,	What does not change is my love,
Ni el recuerdo, ni el dolor	Nor the memory or the suffering

De mi pueblo y de mi gente.

Y lo que cambió ayer,
Tendrá que cambiar mañana;
Así como cambio yo,
En esta tierra lejana.

Of my community and my people.

And that which changed yesterday
Will have to change tomorrow
Just as I am changing
In this far away land.

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APPENDIX 2
Letter to participants before first interview

Preparation for interview

I would like to hear your story about how you became a nurse. In particular, I would like to hear from you:

-What were the important events in your life that shaped you to be the nurse you are today?

-How did you acquire the linguistic and cultural knowledge to be a nurse? By linguistic knowledge I mean how to communicate as a nurse. By cultural knowledge I mean what you do and how you act as a nurse. What do you think the future holds in this area?

-How do you see yourself as a nurse. How has your identity as a nurse developed over the years? Which direction is it going to take in the future?

I do not want to ask you a whole set of detailed questions. I want to hear your narrative, your story. There will probably be more specific questions that will come up as you tell me your story.

STATEMENT OF INFORMED CONSENT

Title of Study: "Life Histories of Foreign Educated Nurses: A Study of Immigrant Foreign Trained Nurses Learning English for Re-accreditation"

If you would be willing to participate in this study, please fill in the information below.

Be sure to keep a signed copy of page 3, and the information on pages 1-2, for your own records.

Please sign your name here to show that you have received pages 1-3 _____.

****

Please sign below if you **consent** to participate in the project outlined on pages 1-2.

Name (please print) _____

Signature _____ Date: _____

Phone number: _____

Witness: _____ Date: _____

Date: _____

PLEASE KEEP THIS COPY FOR YOUR RECORDS.
Thank you very much for your time and consideration!

STATEMENT OF INFORMED CONSENT

Title of Study: "Lives of Foreign Educated Nurses: A Study of Immigrant Foreign Trained Nurses Learning English for Reaccreditation"

If you would be willing to participate in this study, please fill in the information below.

Be sure to keep the extra copy (p.3), and the information on pages 1-2, which are for your own records.

Please sign your name here to show that you have received pages 1-3 _____.

****

Please sign below if you **consent** to participate in the project outlined on pages 1-2.

Name (please print) _____

Signature _____ Date: _____

Phone number: _____

Witness: _____ Date: _____

Date: _____

PLEASE RETURN THIS COPY TO THE RESEARCHER.
Thank you very much for your time and consideration!